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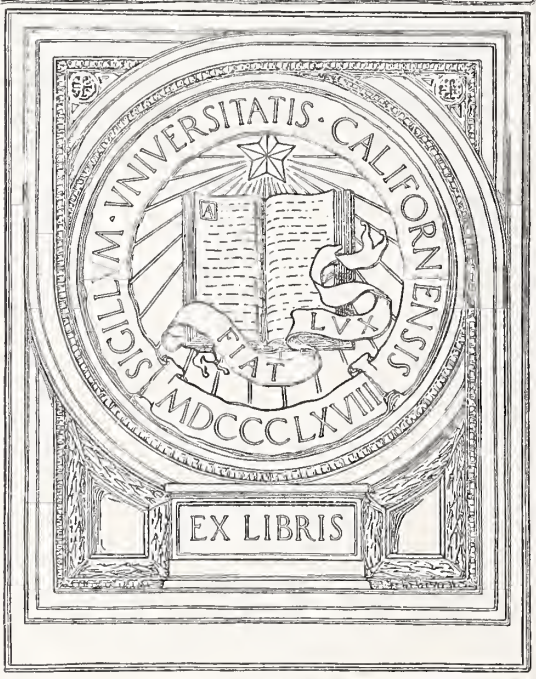

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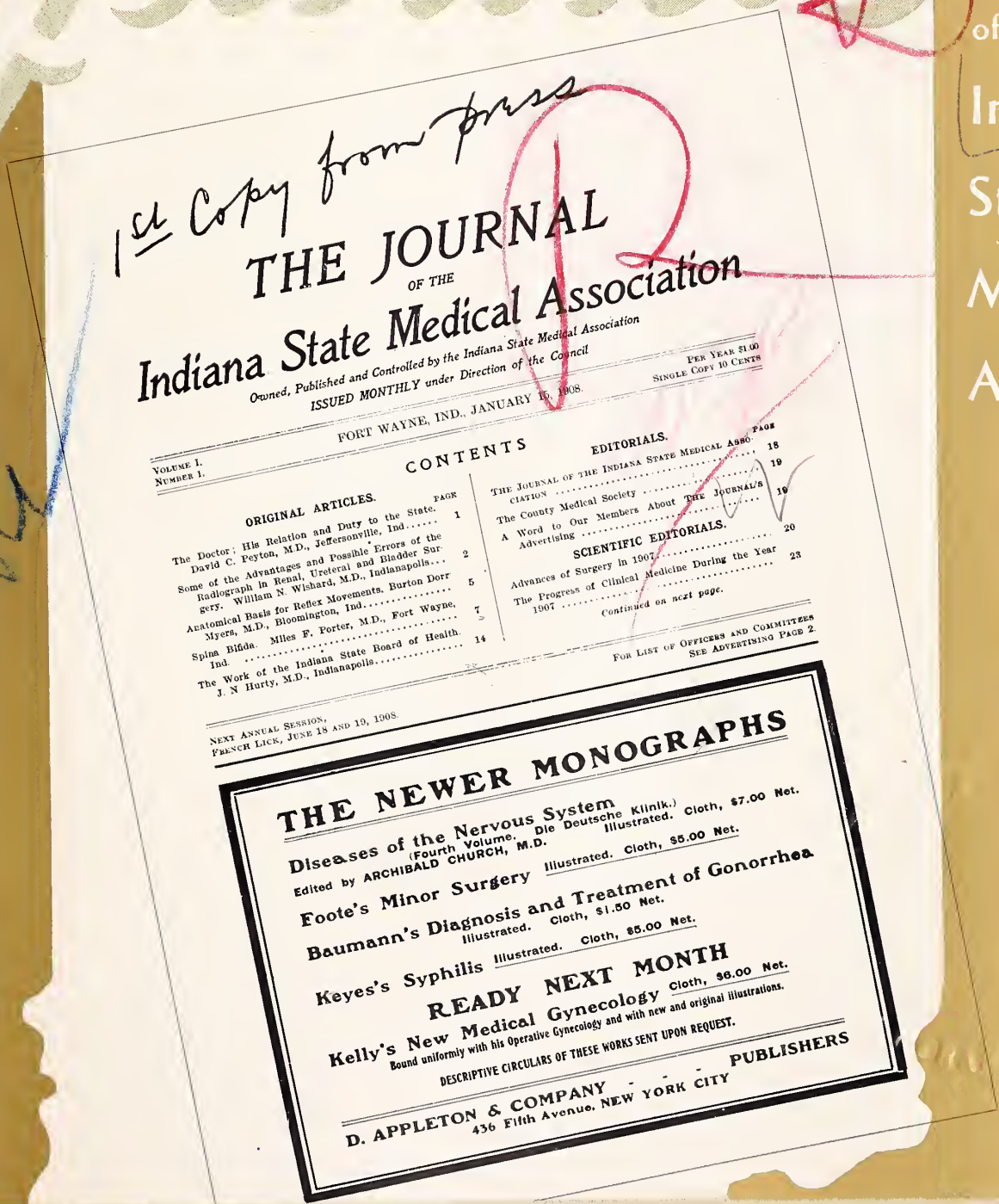

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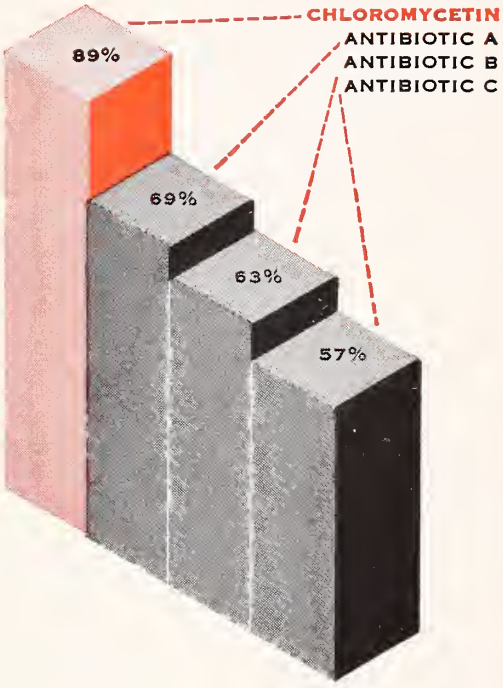

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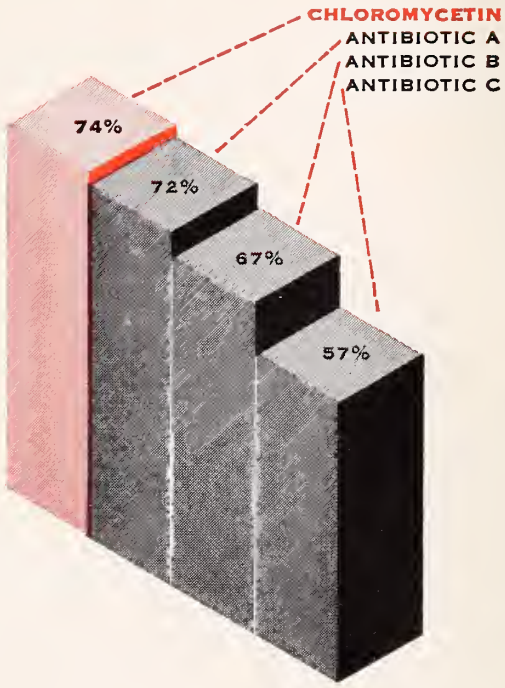

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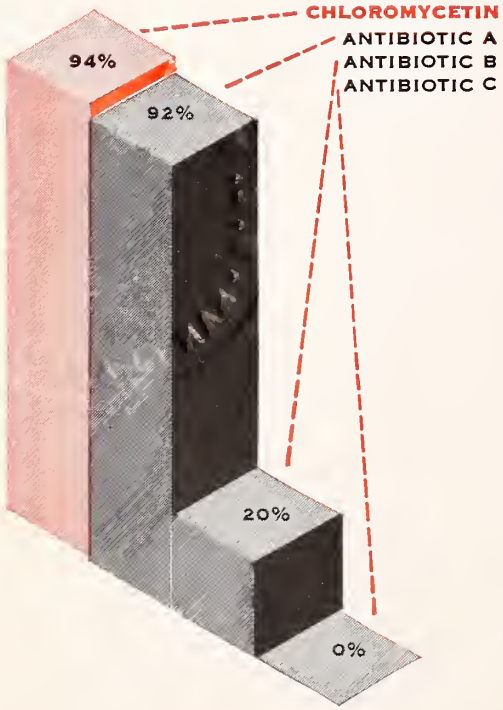

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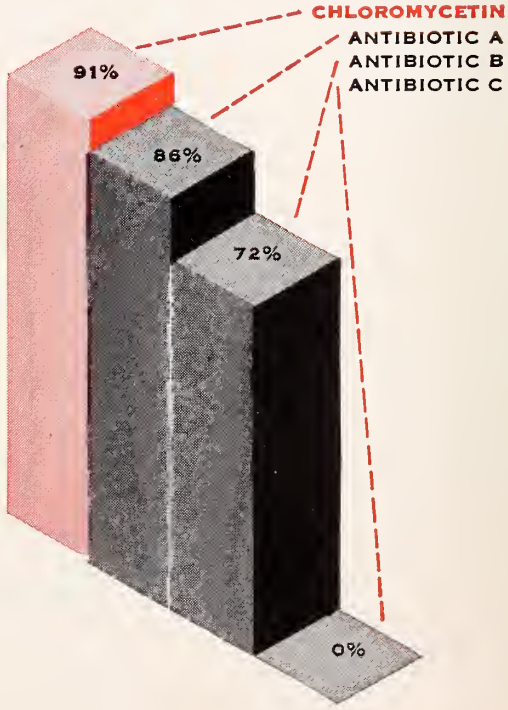

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1. Ende, M.: Am. Pract. & Dig. Treat. 6:710 (May) 1955.

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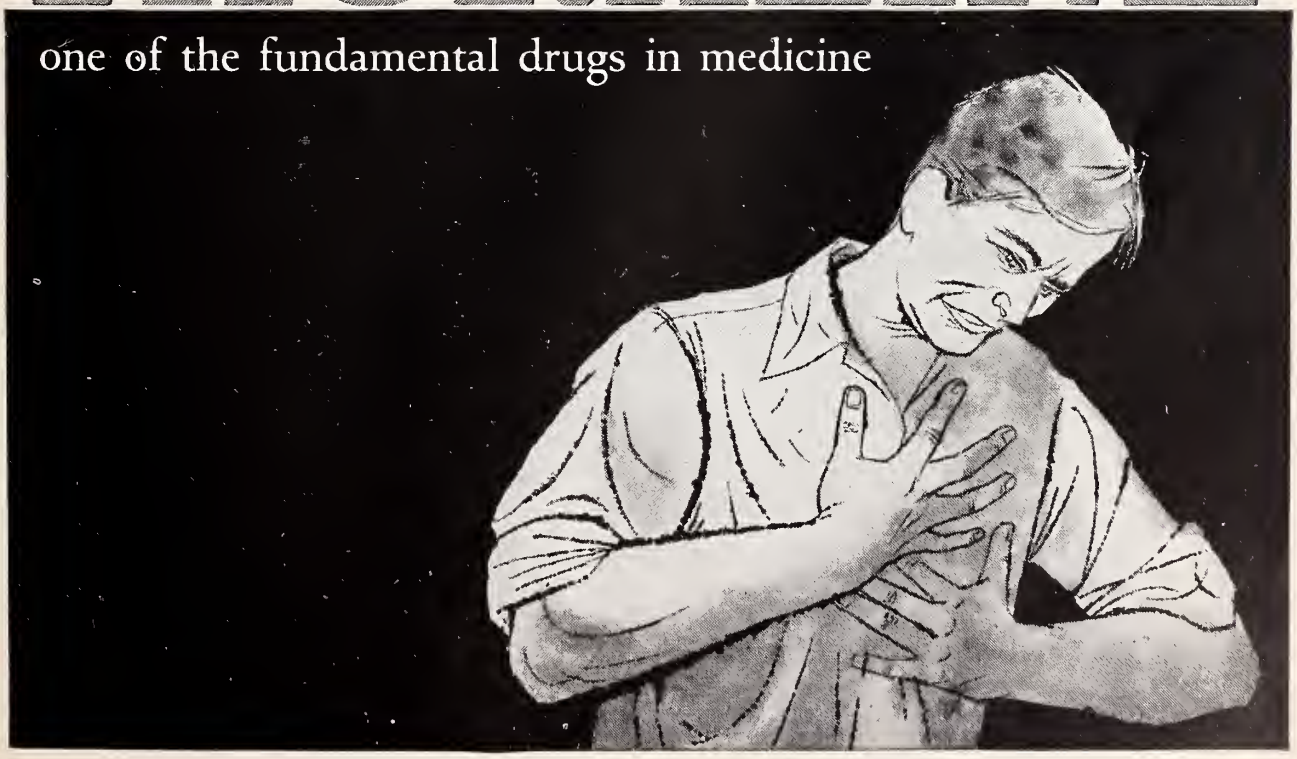

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This summary of what is happening in Washington is prepared by A.M.A.'s capital office and airmailed to THE JOURNAL on the ninth of each month.

THE MONTH IN WASHINGTON

Washington, D. C.—A new venture in federal medical care—the armed forces dependents medical care program—was launched on schedule December 7, and 2 million dependents of servicemen became eligible for hospitalization and extensive medical care.

The "medicare" program, because it is a pioneer effort, will be watched closely by members of Congress, the armed services and the medical profession. Congress will be interested in keeping track of the cost of the program as well as the availability of care.

The Defense Department has earmarked $41 million for the program through next July 1. Thereafter it is estimated the cost will run between $60 million and $70 million a year. When the program is operating at its peak, as many as 800,000 dependents not now getting care at U. S. expense are expected to be participating.

In all but a few states, provision of medical care outside military facilities is being made under agreements signed between the state medical societies contracting agent (generally Blue Shield) and the Army which is the executive agent for Defense.

The contracts run for seven months, and all states are expected to renegotiate contracts prior to their expiration next July 1. New contracts naturally would reflect the experience gained since December 7.

As the vast new project went into force, the newly created Office of Dependents Medical Care (ODMC) stressed that the law intended that civilian medical care under the program should be comparable to that provided in armed services facilities. Participating physicians receive payment in full from the government under a published schedule of allowances. ODMC said this means that the doctor will receive payment for his usual charge or the amount set in the schedule, whichever is less.

ODMC made these additional points:

1. In instances in which the physician believes that an allowance greater than that prescribed in the local schedule is justified, he should look to the government rather than the patient for payment. Provisions have been made for him to submit a special report to his state medical society and, the society, in turn, to the government.

2. Military dependents may submit as identification their post exchange card, the combined post exchange-commissary-military medical care card, or the standard military dependent identification card. A special medicare card is being prepared, and after next July 1 will be the only identification allowed for this purpose.

3. There are no plans in Defense for authorizing payments for drugs, medicinals or other medical supplies, except those furnished while hospitalized or those administered directly by a physician.

4. The claim form to be used by physicians in the medicare program is called "Statement of Services Provided by Civilian Medical Sources." ODMC said sufficient supplies have been furnished by all state agents.

5. The law and implementing regulations do not permit payment for any medical care, services or hospitalization prior to December 7; this includes prenatal care.

* * *

The broad outline of legislative proposals to come from the administration in newly convened 85th Congress was first sketched by HEW

Secretary Folsom in several appearances before newsmen in December. Among them are: (1) federal grants to medical schools for teaching facilities, (2) authorization for smaller insurance companies to pool resources without violating the anti-trust laws in effort to encourage expansion of voluntary health insurance, (3) increased attention to problems of older persons, particularly in health and adult education, (4) continued expansion and improvement in vocational rehabilitation, and (5) expansion of staff and facilities of the Food and Drug Administration.

* * *

Following up President Eisenhower's plea for increased utilization of backed-up stock of Salk poliomyelitis vaccine, Secretary Folsom told a National Press Club audience: ". . . we have a new danger—the danger of public apathy. It is ironic that in the face of such a dread disease, larger quantities of the vaccine are not being used." The President has urged that the vaccine be given additional groups, including young adults.

NOTES

A "package" bill combining both basic and major medical expense insurance is being worked on by the Government for its civilian employees . . . A special advisory committee headed by Dr. Russell Nelson of Johns Hopkins Hospital has asked hospitals to set up pilot projects to see how to revise care given long-term patients in hospitals, and also cut costs . . . The national illness and disability survey voted by the last Congress will be supervised by Forrest E. Linder, Ph.D., former head of social statistics for the United Nations.

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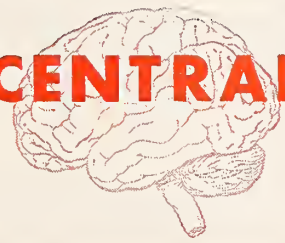

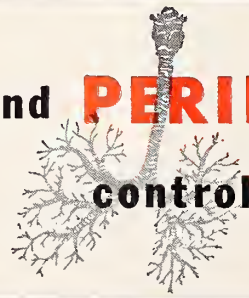

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Books: Received and Reviewed

CLINICAL STUDIES IN NEUROLOGY. By Harry Lee Parker, M.D., M.S., F.R.C.P.I., Professor of Neurology, Mayo Foundation Graduate School, University of Minnesota, Senior Consultant Section of Neurology, Mayo Clinic, Rochester, Minnesota. Cloth. $6.50. Pp. 364. Charles C. Thomas, Springfield, Illinois.

This is a perfectly delightful book, although it seems a strange term to apply to a book on clinical neurology, and may raise serious doubts in the mind of the casual reader either as to the discrimination of the reviewer or the value of the text. There may naturally be doubts as to the reviewer's judgment, a subject always open to question, until one reads the book oneself, but there will be no doubt in the mind of even the most critical reader before he has passed the Biblical note on the first page, that this is a book which may be read for pure pleasure. It will also be a most painless review of the subject of clinical neurology.

The book is actually what appears to be an almost verbatim record of the bedside ward rounds conducted by the author during 12 years of teaching both undergraduate and graduate medical students, in the Richmond Hospital of Dublin. The chapters and the subject matter of the chapters follow a pattern of weekly rounds during an academic year, but therein any semblance to a conventional textbook disappears. Every chapter is a new and enticing adventure into the fascinating experiences of the physician facing not only the medical problems of new patients, but their personal problems and those of their families and friends in the socio-economic structure of Irish society. As a sort of added dividend, like the icing on a delicious cake, are the incidental and constantly recurring references to the historic background of Dublin, steeped as it is with the history and allusion of a venerable medical tradition. And as a still further enticement, if any be needed, each chapter is introduced by a quotation from here and there in any array of literary background, all the way from "Alice in Wonderland" and "Alice Through the Looking Glass" (on which subject, just by the way, the author is an authority) to the Bible. It is apparent to the reader that these quotations are delightfully appropriate and lure one on to the enjoyment of the daily round of neurological problems. No matter how complex or how trivial the diagnosis in each case may be, they are all presented in settings which leave indelible impressions on even the most unretentive mind.

This is a book that no medical student should miss. It will not only teach him neurology in a way that he can never forget, but it will delight and delectate his soul and make him, not only a better doctor but a better person as well. It will be one textbook that he can read for pure pleasure, and that is an experience that is vouchsafed too few of us, and it should also leave him with a feeling of pleasure when he thinks of neurology, instead of the feeling of frustration and unhappiness that has all too often been the presenting feature of neurology as recalled by undergraduates and for that matter graduates as well.

This is a book written for medical students, but it is certainly one that anyone would enjoy not only for its excellence as a textbook of neurology, but because it is wonderful reading for anyone who enjoys a good book. It is probable that most laymen would enjoy it just as much as the physician reader.

LALL G. MONTGOMERY, M.D., Muncie.

MANAGEMENT OF STROKES. By Keith W. Sheldon. J. P. Lippincott Company, Publishers. April 1956.

Dr. Keith Sheldon, a neurosurgeon, discusses the problem of cerebral catastrophes, using the common medical diagnosis of "stroke".

The author justifiably is critical of the attitude of profound finality ascribed to the diagnosis of stroke, further stating that individuals having evidence of a catastrophic cerebral dysfunction too often are victims of stagnant, nonscientific, helpless fog. He further states that the patient who suffers a stroke is deserving of scientific diagnostic approach which has so often been neglected in the handling of such problems.

Doctor Sheldon discusses the proper approach to the management of a stroke and "what not to do" in the handling of these problems. The author emphasizes that lumbar puncture should not be performed until complete neurological examination, including adequate funduscopic examination, has been accomplished.

Differential diagnosis is presented in a thorough and easily digestible manner. Chapters are devoted to the discussion of the intracranial vascular occlusion, the intracranial hemorrhage (spontaneous), intracranial hemorrhage (traumatic), brain tumors and so-called strokes, inflammatory intracranial lesions, and metabolic cerebral dysfunction.

A miscellaneous chapter is devoted to the discussion of other processes which may be misinterpreted as being vascular catastrophes. In this category the author discusses such entities as multiple sclerosis, convulsive disorders, reactions to various drugs and cervical disc syndromes.

The chapter on treatment emphasizes not only care during the acute and critical phases of the illness, but also early establishment of rehabilitation. Although Doctor Sheldon does not offer anything new or different in this respect, case histories illustrate the fact that treatment is not routine or simple.

The author also devotes a chapter to the discussion of neurosurgical procedures of value. He, however, emphasizes the fact that these tests are of little value unless previous studies of clinical nature and observations are gathered together and interpreted properly.

The final chapter is devoted to possible means of reducing the number of "strokes" which now occur. In this chapter the author emphasizes adequate control of hypertension, adequate treatment of cardiovascular disease, the detection of aneurysms and angiomas before serious disability occurs, and the early diagnosis of brain tumors.

Doctor Sheldon writes in an informal, easily understandable, and interesting manner. The chapters on differential diagnosis, containing numerous case histories with comments regarding the diagnostic studies, illustrations of same and courses of treatment that were followed, are felt to be of utmost value. This book is recommended to every physician who has the desire to scientifically study and treat the individual who has experienced a "stroke".

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The Fourth Estate Looks at Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

HEALTH MEASURES IN KOKOMO

We have remarked several times about this community's good fortune in having a health department that gets things done. In the past eight years, health authorities in Kokomo have scored remarkable progress in improving sanitation measures for food consumed by the public, and in eliminating various hazards to health.

Dr. Robert Phares, city and county health commissioner, reviewed this record in an address this week to the Rotary Club. It was a comprehensive review, one worthy of the community's approval.

The Grade A milk ordinance, the restaurant grading ordinance, the ordinance requiring vaccination of dogs as a precaution against rabies, the elimination of 1,100 outdoor toilets in the city, abandonment of a risky method of garbage disposal in favor of a modern and scientific one, fluoridation of the city's water supply to protect children's teeth, and other measures were referred to by Dr. Phares.

In pressing for these programs the health department has had the firm support of city administrations, both Democratic and Republican. The city hall, regardless of its political complexion, and the city council, no matter what its political majority, have backed the health program superbly.

We hope that the high standards envisioned in the inspection of food-serving establishments, food markets and milk processors are being maintained by the inspection program.

We believe a further gain would be made in the overall health of the community if the health department's recommendations for inspection of meat and for extension of the restaurant and food market inspection into the county could be carried out.

All meat intended for human consumption ought to be examined by qualified experts before it is sold. To install such a program here would be very expensive—estimates are that it would cost $25,000 or more a year—because of the difficulty of finding trained experts who can spot imperfections in meat that may have been overlooked by packers.

But the recommendations should be considered carefully and, if possible, favorably.

—Kokomo Tribune

TRANQUILIZING DRUGS

Americans are prone to seize upon new remedies for old ailments. So much has been said and written about wonder drugs that there is a tendency to depend upon them in almost any situation.

It is thus no surprise that the so-called tranquilizing drugs have gained widespread popularity in a very short time. A startling number of people are taking such drugs to relieve tension and anxiety.

Now it is beginning to be clear that numerous physicians have doubts as to whether such drugs are entirely beneficial. It is being suggested that in some cases their harmful effects may outweigh their value. More tests are needed. Therefore, it is good news that the U. S. Public Health Service is undertaking a thorough study of the tranquilizers.

—Kokomo Tribune

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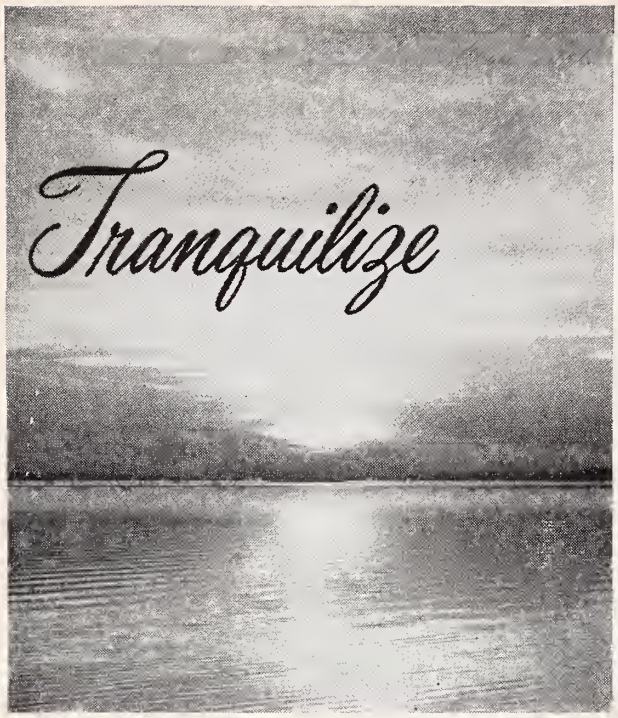

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Abstracts:

ADRENOCORTICAL STEROIDS AND TUBERCULOSIS

Golding, I. M., Lester, W., Jr.; Berg, G. S.: New England J. Med., 254:1026-1028, 1956.

Of the commonly accepted actions of these drugs, two, namely: the sense of well-being, and the depressed connective tissue reactivity, combine to permit extension of tuberculous activity without symptoms therefrom. Tuberculous patients who receive steroids may respond with decreased fever, increased strength, improved appetite, gain in weight, and a feeling of well-being while showing no change or worsening of their x-ray picture.

Case records are given of two patients with no previous history of tuberculosis who developed rapidly progressive and severe pulmonary lesions while on steroid therapy for arthritis.

The Committee of Therapy of the American Trudeau Society in 1952 recommended that when cortisone is given to known, old, but apparently inactive cases of tuberculosis, there should first be evaluation for activity, then frequent follow-up x-ray examinations and sputum studies after treatment is started and that in the absence of known tuberculous infection x-ray examination of the chest before, during, and after hormone treatment is advisable.

Tuberculous patients who urgently need steroid therapy can probably receive it safely if at the same time they are protected by a standard regimen of anti-tuberculosis drugs.

Stephen L. Johnson, M.D., Evansville.

SOME ABUSES OF DRUGS IN THERAPY

Friend, D. G., McLemore, G. A., Jr.: New England J. Med., 254:1223-1230, 1956.

New drugs are being marketed faster than doctors can learn how to use them. In 1940 about 95 new drugs were introduced and in 1954, 550. Often these drugs are placed in the hands of doctors before all the clinical studies are adequate. Competition between drug houses results in a variety of trade names for a single product and a variety of dosages for products that are similar. Because of the above, the use of new drugs is resulting too frequently in such things as drug addition, blood dyscrasias, endocrine imbalances, drug allergies, and electrolyte abnormalities. "Multiple ingredient" pharmaceuticals prevent adequate adjustment of dosage of the drugs to the individual patient.

A plea is made for a return to the use of morphine in apprehensive patients since Demerol fails to induce the feeling of well-being derived from morphine. The increasing rate of drug addiction from Demerol is mentioned with a statement that

(Please turn to Page 20)

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Abstracts: (Continued)

about 30 percent of those addicted are physicians. A warning is given against the use of Nalline in an addicted person since it precipitates the withdrawal syndrome, and at times fatally. A test dose of 2 or 3 mg. should be given to such a person rather than the usual 10 to 20 mg.

Note is taken of the increasing combination of salicylate with steroid therapy with the warning that each of these types of drugs is capable of causing gastro-intestinal ulceration with hemorrhage or perforation.

The suicide rate from barbiturates has increased 400% since 1935 so that they are now second to carbon monoxide as a suicidal agent. The withdrawal of barbiturates from an addict may produce severe withdrawal symptoms. Of addiction, they say, "Any drug that excites, distorts, or sedates mental function has inherent in it the possibility of causing addiction".

For treatment of mild hypertension a dosage of 0.1 mg. to 0.25 mg. reserpine daily is suggested. This is probably much less than is commonly used.

A return to the use of Sippy powders in treatment of painful peptic ulcers would quicken pain relief and promote more rapid healing than is obtained with our current aluminum and magnesium mixtures. The flexibility in dosage of tincture of belladonna allows more adequate control of gastro-intestinal spasm than do the newer tablets.

Habitual use of mineral oil is condemned because of the frequency of lipoid pulmonary damage.

The severe vasomotor reactions seen following withdrawal of estrogens are interpreted as a withdrawal symptom following addiction to these hormones and should be treated by gradual withdrawal and psychotherapy.

The progression of the neurologic signs of pernicious anemia seen following treatment with multiple vitamin mixtures containing folic acid is mentioned.

The article represents a detailed common sense approach to the problem of new, at times complex, often useless drugs.

Stephen L. Johnson, M.D., Evansville.

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I^{-131} in the Treatment of Toxic Goiter*

LINDEN SEED, M.D.**

Chicago

SINCE THE PROBLEM of whether one should or should not use I^{-131} in the treatment of toxic diffuse goiter revolves chiefly around the fear of producing cancer or the fear of producing unfavorable effects on the genes, these matters perhaps warrant first consideration in a discussion of therapy with I^{-131}. The objections to the use of radioactive iodine, although largely hypothetical and theoretical, are nevertheless of sufficient importance to be the chief limiting factors in its clinical application.

Will radioactive iodine cause cancer of the thyroid in the human? The experimental evidence in animals is scanty. In fact, there are only two confirmatory reports. Goldberg and Chaikoff[9] found carcinomas of the thyroid in 7 of 25 rats one and a half to two years following the injection of 400 microcuries of I^{-131}. Large numbers of rats, mice, and other species given I^{-131} by other investigators have developed adenomas in some instances, but never cancer. In one other investigation Doniach[6] found that carcinomas developed in 5 of 20 rats given I^{-131} and methylthiouracil. Thiouracil alone produced adenomas only; I^{-131} added to the thiouracil increased the formation of adenomas and induced cancer; while I^{-131} alone did not cause cancer. Thyroid tumors in animals are frequently dependent on a state of hypothyroidism. It is possible that internal radiation to the thyroid produces a nuclear alteration which can become cancerous as a result of stimulation from the physiologic response to hypothyroidism. Doniach[6] thinks that the present dosage used in thyroid therapy may eventually prove carcinogenic and in view of the possibility that I^{-131} renders the thyroid epithelium sensitive to overstimulation, he recommends that thyroxine medication should be instituted after thyrotoxic symptoms are relieved in cases of Graves disease. On the basis of his experiments, antithyroid therapy should not follow I^{-131} therapy. In addition to the above observations, there are a number of bizarre changes in the nuclei in thyroid glands of humans and animals subjected

* Delivered at the 107th Annual Convention of the Indiana State Medical Association on October 17, 1956 in Indianapolis.

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to I^{131} irradiation that might be considered morphologically precancerous.

This about summarizes the factual evidence on the carcinogenic effect of I^{131}. Recently, however, some circumstantial evidence has been presented suggesting a causal relationship between radiation and carcinoma of the thyroid. Duffy and Fitzgerald[7] in a survey of 28 cases of thyroid carcinoma in children and adolescents under 18 years of age found that 10 cases in this series had irradiation to the thymus gland between the fourth and sixteenth month of life. Simpson et al.[22] traced 1,400 of 1,722 cases treated by x-rays in infancy for thymic enlargement, and at the same time determined the status of health of 1,795 untreated siblings. Seventeen (possibly 19) children of the treated group had some form of cancer, 6 had cancer of the thyroid, 9 had adenomas of the thyroid, and 7 children had leukemia. Of the untreated children 5 had cancer other than the thyroid, and 1 had thyroid adenoma. None had leukemia. Clark[3] has reported that of 15 children with carcinoma of the thyroid, 15 years of age or under, all had previous x-ray to the neck. Winship[25] in a survey of 334 cases of thyroid carcinoma in children under the age of 15 found a history of thymic radiation in 20 percent. I have treated 9 children or adolescents with carcinoma of the thyroid, one 17 years of age, one 16 years old, the others 12 years old or under. Five had previous x-ray treatment in childhood or infancy, one for obstructive dyspnea due to an enlarged thymus, two for large tonsils, two for glands of the neck which may or may not have been metastases from an already existing carcinoma of the thyroid. Uhlman[24] is not in accord with the theory of a causal relationship. Quimby and Werner[18], as the result of a questionnaire sent to 101 radiologists and thyroid specialists, concluded that x-ray therapy to the neck in adults did not lead to cancer of the thyroid. Nevertheless, the above observations have caused some consternation among those physicians who have been inclined to treat younger patients, and has, for the time being, eliminated children from consideration.

The carcinogenicity of radiation is an established biologic fact, but to the present moment there has been no reported instance of a tumor of the human thyroid caused by therapy with I^{131}. Fifteen years have elapsed since the first patients were treated in 1941 by Hertz and Roberts[12] at Massachusetts General Hospital and by Hamilton and Lawrence[10] at the University of California. Actually the treatment has been in general use for only the past 10 years. The fact that since 1946 thousands of patients have received therapeutic doses of I^{131} without a single recorded instance of subsequent carcinoma is sufficient evidence to dismiss this possibility for a life expectancy of at least 10 years. If no cancers have appeared during the first decade, it is very unlikely that enough would appear during the second decade to equal the surgical deaths following thyroidectomy. Furthermore, since the entity of cancer following I^{131} internal radiation is unknown, one might postulate that it might or might not be a mild form of the disease, that it might be amenable to treatment, that it might not necessarily be immediately fatal and the patient might live a few years after its onset. Such circuitous reasoning permits the surgeon to grudgingly recommend I^{131} in all patients with a life expectancy of 20 years and the internist blithely to those with a life expectancy of 30 years.

Any dose of radiation may cause damage to the genes.[15] The number of roentgens to double the mutation rate in man has been estimated at from 300 r to 3 r.[19] The amount of radiation to the gonads in the I^{131} therapy for hyperthyroidism is not large—approximately 1 r per millicurie dose. The total dosage would approximate the normal radiation received by a human during a life span. The danger of radiation mutagenesis is not great; however, this fear could be easily removed by confining I^{131} therapy to people not likely to bear children.

I^{131} THERAPY IN TOXIC DIFFUSE GOITER

Mechanism: When a patient with a toxic diffuse goiter ingests radioactive iodine, from 60 percent to 70 percent of the dose is concentrated in the thyroid gland within 6 to 12 hours, and the remainder is excreted in the urine. Destructive radiation of the gland is effected primarily by the beta rays of I^{131} which have a maximum range of about two millimeters. The gland is thus selectively destroyed without noticeable effect upon the contiguous structures and without radiation damage to other structures in the body. No other element in the body has

such a limited or selective biologic activity; and no other isotope has had the clinical application.

Indications: Before outlining the indications for definitive therapy with I^{131} and surgery, one must emphasize the fact that the symptoms of exophthalmic goiter can be controlled in many patients, perhaps 30 percent, by treatment with iodine and the anti-thyroid drugs. (Table I)

TABLE I

Indications for Medical Treatment in Toxic Diffuse Goiter

1. Symptoms mild.
2. Not much goiter.
3. Little exophthalmos.
4. Patient not too old.
5. No other complications.
6. Questionable diagnosis.

Since a diffusely hyperplastic thyroid can be destroyed practically without exception by the simple process of taking a drink of water with a few millicuries of NaI^{131} in it, the indications in this type of goiter would be unlimited except for the reasons as outlined above. (Table II)

TABLE II

Indications for I^{131} Therapy in Toxic Diffuse Goiter

1. Patients over the age of 40.
2. Post-operative recurrence.
3. Idiosyncrasy to I_2 and perhaps to the anti-thyroid drugs.
4. Refusal of surgery.
5. Complications that increase risk or shorten life expectancy.
6. Severe exophthalmos.

The indications for I^{131} therapy are based upon cautiousness rather than a statistical evaluation of results. Many, if not most, authorities, as exemplified through recent papers by McCullagh[14] of the Cleveland Clinic, Hamwi and Goldberg[11] of Ohio University, Bierwaltes[1] of the University of Michigan, Clark[4] of the University of Chicago, and Chapman[2] of Harvard Medical School (an excellent review), take the age of 40 as the dividing line between surgery and I^{131}. The line stretches considerably both above and below the number 40, depending on whether the counseling physician is a protagonist of surgery or radioiodine therapy, but it is a sensible figure to follow, in part because it obviates the theoretical dangers, and in part because it is by common consent recognized and accepted. If, for instance, there is no palpable goiter, I would be inclined to use I^{131} at the age of 30, or even less, with the reasoning that, if there is not much enlargement, there is not much to remove and a small goiter is easily cured by a small dose of I^{131}. For the contrary reasons, if the goiter were quite large, I would prefer to remove it even at the age of 50. One must also consider the varying degrees of surgical competency to which the patient will be subjected. The threshold for operative interference may be quite low in an organized goiter clinic and is justifiably much higher where a thyroidectomy is relatively uncommon. One should not delude himself into believing that the surgical results as reported in the literature are uniform throughout the land. By the nature of things, the reported results are the very best results obtainable. A post-operative recurrent goiter at any age justifies the routine use of I^{131}. The recurrence in itself is presumptive evidence that an operation is none too successful in this particular patient, and I^{131} might be preferable to another operation, a bit of logic that usually appeals to both the patient and the surgeon. An idiosyncrasy to iodine which prevents its administration is an obvious indication. The same is true of any idiosyncrasy to the anti-thyroid drugs in a patient whose symptoms cannot be adequately controlled by iodine alone. Some patients refuse to be operated on. In a few some complicating disease may increase the surgical risk or reduce life expectancy to the point where I^{131} treatment is advisable. If a patient has a questionable diagnosis of hyperthyroidism, medical therapy, or at least a therapeutic diagnostic test, is indicated. If definitive treatment becomes imperative, it is perhaps the better part of valor to use I^{131}; for if one perchance is not going to cure the patient, it is much better not to cure him with I^{131} than not to cure him by an operation.

The preceding indications are agreed to by many clinicians. The last one, namely, severe exophthalmos, is not. Only Clark and Rule[4] specifically advise I^{131} when there is severe exophthalmos because it is their opinion that radiotherapy gives better results for exophthalmos than does surgery. Because a thyroidectomy in an exophthalmic patient is usually followed by

an improvement in the exophthalmos, it was my custom in the past to do a total thyroidectomy for severe or progressive exophthalmos, and then give the patient desiccated thyroid. The results were satisfactory. At present, it is much safer and easier to produce complete myxedema with I^{-131} and follow with desiccated thyroid therapy. This mode of attack has also been followed by good results.

Contraindication: The only absolute contraindication to radiotherapy in a toxic diffuse goiter is pregnancy after the 14th week when the fetal thyroid begins to develop the function of accumulating iodine. The relative contraindications are children, patients under the age of 40, and patients with large goiters. Of course, I^{-131} is not advisable in non-toxic goiter whether diffuse or nodular.

Dosage: The dose from a purely scientific point of view depends upon three at least partially assessable factors: (1) the percent of thyroid uptake of I^{-131}, (2) its effective half-life (EHL) in the gland, and (3) the size of the gland. Two other factors that cannot be assessed influence the effect: (1) the distribution of the radioiodine throughout the gland and (2) the degree of radiosensitivity of the thyroid epithelium. Actually the errors in calculating the uptake, the EHL, and the size of the gland are so great that the effort to calculate them and predict the dose in roentgens as calculated from the tracer dose is not very profitable.[21] In addition, even if one could calculate and administer the exact dose in roentgens, he could not predict the end result. It is possible to obtain hypothyroidism with a dose as little as 4,000 equivalent roentgens while in another patient 40,000 equivalent roentgens merely produce a euthyroid state. From a practical point of view, the dose depends upon (1) the desire to avoid myxedema, (2) the size of the gland, and (3) the percent of uptake. A reasonable basic dosage rate is 100 microcuries per gram accumulated in the thyroid gland. This figures out as 5, 6 or 7 millicuries in a woman with an enlargement of the thyroid gland which is just visible, and 6, 7 or 8 millicuries in a man with a barely visible goiter. (In the latter the gland is somewhat larger.) If the gland is larger than usual, add two or three millicuries; if it is very large, double the dosage, and even then expect to treat the patient a second time. The material seems more effective in young people. In them it is well to begin with lesser quantities. In each patient one must choose one of three dosage levels, namely, too little, just right, or too much. Usually the circumstances will readily dictate the decision. The majority of clinicians using I^{-131} attempt the highest possible cure rate with the first dose. This policy will result in euthyroidism in approximately 60 percent of the cases, hypothyroidism in 10-15 percent, and persistent hyperthyroidism in 25-30 percent. A number of physicians follow a much more conservative policy, giving doses of two or three millicuries repeated as many times as necessary. Some, by this means, can reduce the incidence of permanent hypothyroidism to as low as 2 percent. These results are in part due to the method per se, but also in part due to good clinical judgment based upon experience.

Health Hazard: The ingested radioiodine takes two routes, one to the neck and one through the kidneys. For a short time after the drink the mouth is radioactive. Most of the excess of I^{-131} is excreted during the first 24 hours, and nearly all of it in 48 hours. During this time the urine is definitely radioactive, and extra care should be exerted to prevent contamination. Fortunately radioactive NaI^{-131} is easily washed from clothing, bed linen, the body, or the hands. If the patient is hospitalized, the linen is surveyed with a geiger counter before being sent to the laundry. If the patient is at home, contaminated linen should be washed out at home. A varying amount of radiation is concentrated in the neck, but it is not enough to compel the patient to sleep alone. If the patient is, perchance, caring for an infant, it would be wise to avoid cuddling the baby, or holding it for long periods of time. The half-life in the neck averages five days; there is only 5 percent of the dose remaining in three weeks. The health hazard is minimal and may be largely disregarded in out-patients.

Normal Clinical Response: For the first two or three days there may be slight discomfort about the neck accompanied by mucous and cough. There is some exacerbation of symptoms for the first four or five days, usually not severe enough to be noticed by the patient, but enough to warn most patients to avoid unusual physical exertion during the first week. The first evidence of the effectiveness of the dose begins in about two weeks with a diminution in the size of the goiter—this appears even before clinical

improvement. In about three weeks there should be some amelioration of the symptoms. If the improvement is quite marked and the patient is volubly elated over the result, one can suspect strongly that the state of euphoria will pass over into a state of hypothyroidism with the passage of a few more weeks. Improvement continues into the third month, but the basal metabolism may continue to drop for another two or three months, then rise and become stabilized in six to nine months from the date of treatment. The effect on the exophthalmos is the same as that of a thyroidectomy. The stare improves, puffiness may be increased, and protrusion remains the same. At about three weeks one can guess whether or not the dose will be completely effective. At two months the end result is fairly well established and the situation can be re-evaluated as to whether the patient is euthyroid, hypothyroid or hyperthyroid. Persistent hyperthyroidism requiring a second dose is quite common (25-30 percent) ; a third dose is uncommon (10-15 percent) ; and a fourth dose is very rare (less than 5 percent). True recurrence is probably in the neighborhood of 5 percent. We have had one patient who had a frank hypothyroidism requiring 120 mg. of desiccated thyroid daily for two years, and then developed hyperthyroidism severe enough to require another therapeutic dose.

End Results: A survey of the cases treated up to 1952 are tabulated in Table III.[20]

TABLE III

Summary of End Results of the Treatment of Hyperthyroidism with I^{131} to 1952

	Number	*Percent*
Total	1720	100
Satisfactory Remission	1373	80
Became Hypothyroid	151	9
Unsatisfactory Result	86	5
Incompleted Died Later	110	6

A cursory review of recent reports indicates about the same results. It is probable that all cases of exophthalmic goiter can be controlled by I^{131}. As long as thyroid tissue has the ability to accumulate iodine, it can be destroyed. Fortunately, hyperplastic thyroid apparently never permanently loses this capability as long as it is functionally overactive. It is relatively simple to produce myxedema. Indeed, it is difficult to avoid it. The end results following internal radio-therapeuses compare favorably to the end results following thyroidectomy except in the higher incidence of myxedema.

Untoward Results: In two patients we have seen a violent radiation thyroiditis occurring within 12 hours after giving the dose. One occurred in a patient with a carcinoma of the thyroid who was given 15 millicuries in order to destroy a remaining lobe. The other occurred in an exophthalmic goiter following a dose of 7 millicuries. Both patients required morphine injections for the control of pain. In five instances we have seen severe hyperthyroid reactions beginning in 24 hours or less. One patient with a toxic nodular goiter was semi-comatose and practically moribund at the time of treatment. The other four had severe hyperthyroidism from toxic diffuse goiter. On the other hand we have given relatively large doses —up to 15 millicuries—in two bed-ridden patients who were ill enough to be in oxygen tents and in two patients approaching a crisis without noticeable exacerbation of the symptoms and with excellent end results. If a reaction does occur, it can be terminated by the administration of Lugol's solution. This action also washes out I^{131} into the urine and diminishes the effectiveness of the treatment, and as a consequence should be postponed, if possible, until a week has passed.

Two deaths have been reported due to a thyroid crisis soon after I^{131} treatment.[8, 16] One case of parathyroid tetany has been recorded[23]—this is difficult to understand. One case of leukemia has followed treatment for hyperthyroidism.[17] There have been two cases following treatment for cancer. Two cases of carcinoma of the larynx have been reported in patients soon after receiving therapeutic doses.[13] A causal relationship, however, is doubtful.

I^{131} IN TOXIC NODULAR GOITER

Toxic nodular goiter is basically a surgical disease. Nevertheless, there are a number of patients in whom the surgical risk is very high who can be given I^{131} either for definitive treatment or for pre-operative treatment. The most

common indication is a woman past 70 years of age with a decompensated heart or some other complicating disease. Rather frequently an elderly patient will flatly refuse to be operated on. Sometimes, if the surgical risk is too great, I^{131} can advantageously be used as pre-operative treatment. Nothing is lost and much may be gained. This decision to use or not to use I^{131}, however, should be made immediately. Normally the pre-operative preparation of a toxic nodular goiter consists of the administration of propylthiouracil or tapazole over a period of at least two months. If iodine is also given, the gland becomes saturated and loses its ability for a long period of time to accumulate a therapeutic dose. This is not true in exophthalmic goiter where iodine medication can be stopped, and in a week the gland recovers its ability to trap iodine. How long it requires in a toxic nodular goiter I do not know, but in most cases it is too long to permit I^{131} therapy. Pre-operative treatment is quite simple. A tracer dose is administered to determine if there is an uptake adequate enough to justify giving I^{131}, a large (25 millicurie) therapeutic dose is administered, and ten days later regular anti-thyroid therapy is instituted. The gland will shrink. The surface may be glued a little more closely to the surrounding structures, but the operation is no more difficult. In fact, because of the reduction in the size of the gland and in its friability, the operation may be easier to perform. Because adenomatous goiters are often very large, an adequate uptake is particularly essential. In spite of the fact that a nodular goiter may be quite toxic, occasionally the uptake may be less than 20 percent, and it is nearly always less than in toxic diffuse goiter. If the goiter is very large and the 24-hour uptake is, let us say, only 35 percent, a cure will be difficult to obtain. In this circumstance thyroid stimulating harmone (TSH) may help. The clinical application of TSH in such a situation has not been crystallized. The material is now obtainable commercially from Armour Laboratories under the proprietary name "Thytropar" in ampules containing ten units. It is injected intramuscularly. A tracer dose is given, and the thyroid uptake calculated. The process is repeated with a therapeutic dose. The optimum time after the injection at which to give the dose is not established. It definitely enhances uptake if the drink is taken simultaneously with the injection. It also increases uptake if it is taken 24 hours later.

The dose in toxic nodular goiter is high, very high. The uptake is never high; the glands are large, and the tissue is not as radio-sensitive as a diffusely hyperplastic thyroid. One could establish a minimum dose of 25 millicuries without much error, and expect to repeat it in a few months. As an indication of the larger amounts required, Cook, Jones and McCullagh[5] of the Cleveland Clinic treated 21 patients with an initial dose of 20 to 40 millicuries and 10 patients with initial doses of over 50 millicuries. Additional doses were required in 10 of the first group and in only 3 of the second group. There was no instance of increased thyrotoxicosis or of aggravation of the patient's cardiac status, and no instance resulting in myxedema.

Improvement in toxic nodular goiter is not as rapid nor as complete nor as certain as in exophthalmic goiter. The nodules become smaller and more firm, but do not disappear. A second dose is often necessary and frequently a third and fourth. Occasionally following a therapeutic dose, although the patient is still hyperthyroid, the uptake of the gland is reduced to a point where a succeeding dose is no longer profitable.

SUMMARY

I^{131} in the treatment of toxic goiter has been discussed briefly under the following headings.

I. Theoretical and hypothetical objections.
   Cancer.
   Mutations.

II. I^{131} in toxic diffuse goiter.
   Mechanism.
   Indications.
   Contraindications.
   Dosage.
   Health hazard.
   Clinical response.
   End results.
   Untoward results.

III. I^{131} in toxic nodular goiter.

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Latent Spontaneous Evisceration Of an Abdominal Wound*

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INTRODUCTION

LATENT SPONTANEOUS evisceration through a ventral hernia is apparently an extremely rare occurrence. Although there is little information available on this subject, a review of the literature revealed one article by Chavannaz in 1900[1] which discussed a series of such cases, one of which occurred several years following surgery. Because the following case is unusual we think it warrants publication.

CASE REPORT

Mr. F. G., a 63 year old white male, gave a history of accidentally falling off of a porch, a distance of approximately fifteen feet, on January 3, 1954. He sustained a ruptured bladder, a fracture of the neck of right femur, right forearm and of the eighth, ninth, tenth and eleventh ribs, right. Both rami of the pubis were also fractured and he sustained multiple lacerations of the face. On the date of injury he was admitted to the Louisville Veterans Administration Hospital. A suprapubic cystotomy was performed on January 3, 1954 for the ruptured bladder. Postoperatively this patient developed an ileus which was relieved by Levin tube suction. On January 8, 1954, the patient was able to tolerate a full diet and it was noticed at that time his blood proteins were poor. He subsequently developed a ventral hernia through the suprapubic cystotomy scar. The patient's hernia was asymptomatic until July 20, 1954, when he was admitted to the Veterans Administration Hospital, Dayton, Ohio because of a spontaneous evisceration of small bowel through the old abdominal incision. The patient stated that while arising from bed on the day of admission, he felt a sudden giving way sensation in his lower abdomen in the region of the hernia. He noticed the bulging of intestine on his abdomen and came immediately to the hospital via ambulance.

Physical examination on admission to the hospital showed a fairly well developed and rather poorly nourished 63 year old white male in apparent acute distress. There was a six inch midline suprapubic scar, with an opening through the abdominal wall in the upper one third, through which protruded a loop of small intestine. The intestine appeared slightly cyanotic but there was no evidence of gangrene. (Refer to Figure 1). The laboratory findings, including serum proteins, were not remarkable.

Soon after admission the patient was taken to the operating room and closure of the abdominal defect was begun under spinal anesthesia. On inspection of the wound there was a midline suprapubic scar extending from the umbilicus to the symphysis pubis. At the junction of the middle and upper one-third of the scar there was an opening approximately three-fourths of an inch in diameter which permitted the extrusion of about ten inches of small intestine. The bowel was slightly cyanotic due to congestion but no gangrene was present. The abdominal wall opening was extended and the intestine was washed with sterile saline solution and then replaced in the abdomen. Several small bowel adhesions were lysed and the redundant portions of the skin and peritoneum were excised. The fascial edge of the rectus muscles were exposed and sutured with catgut because of gross contamination of wound. Six through and through wire retention sutures were used to support the closure. Postoperatively the patient's course was un-

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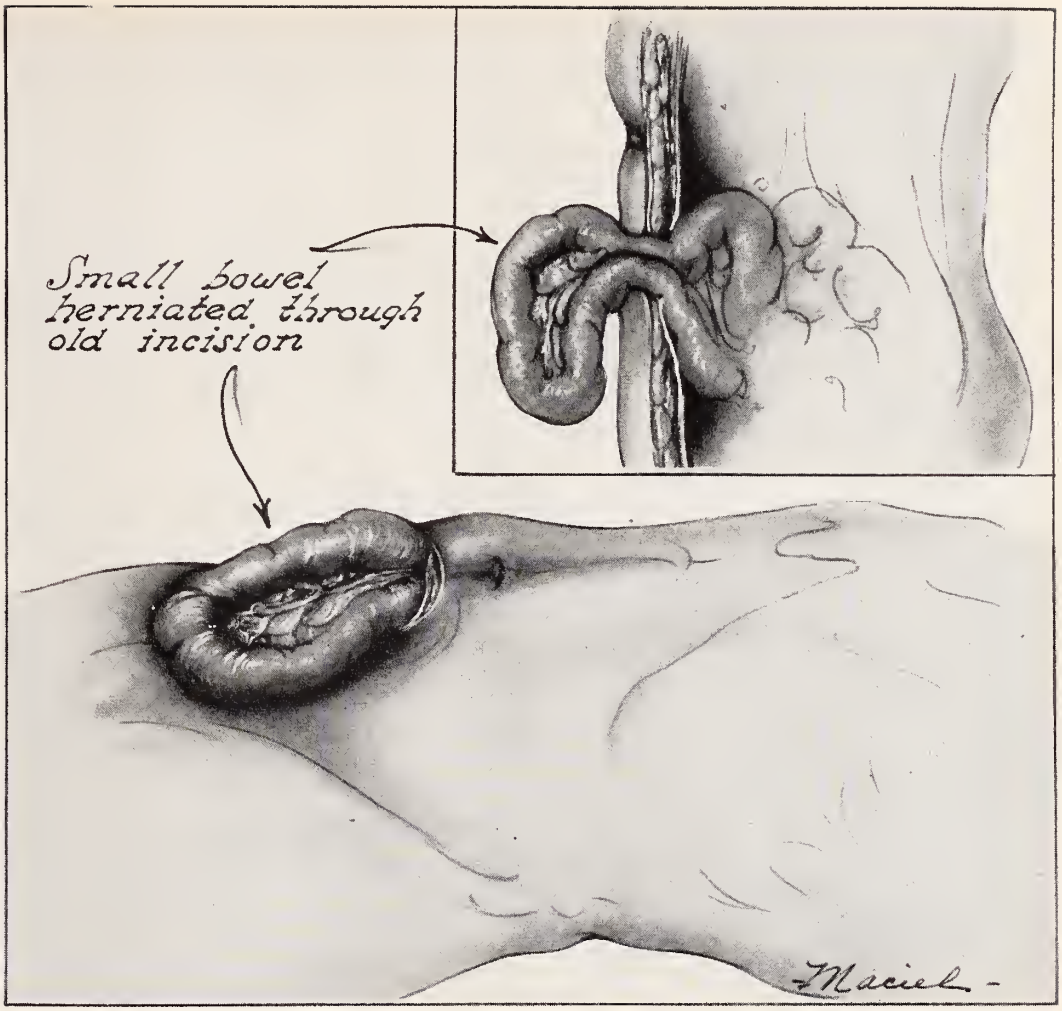

Figure 1

eventful and the wound healed per primam. All skin sutures were removed by the eighth postoperative day and retention sutures were removed on the twenty-first postoperative day. Patient was subsequently discharged with a strong taut wall, with no evidence of persistent hernia.

COMMENT

This case is interesting due to the fact that latent or tardy spontaneous evisceration through ventral hernias is rarely seen. In reviewing the literature, it appears that latent spontaneous evisceration through abdominal incisions is not too frequent. Chavannaz (1900)[1] reported a series of five cases all of which were classified as cases of latent spontaneous postoperative evisceration. These occurred from six months to over two years after operation. Surgical repair of a hernia had been effected in many instances and in most cases a recurrence of the hernia had taken place before spontaneous evisceration. Martin (1889)[2] reported one case occurring about eight years later.

Spontaneous evisceration may be divided into early and late types. Latent spontaneous evisceration by definition is that type which occurs later than would normally be expected following surgery. Any evisceration occurring therefore after the first 30 days postoperatively should be considered as latent type. Hull and Hankins (1955)[3] discussed the mechanism of wound disruption as being a dissecting wedge of omentum which may have been forced through a poor peritoneal closure in the first few hours after operation. Coughing, distension, retching, hiccoughing and vomiting all predispose to this condition. The degree of progression thus determines whether the wound will eviscerate immediately or not. Prompt evisceration is the rule. Mersheimer and Winfield (1955)[4] analyzed general factors that retard wound healing and predispose to disruption. Some of these factors are advanced age, malnutrition, vitamin deficiencies, anemia, dehydration, hypoproteinemia, malignancy, chronic systemic disease (diabetes). There were several factors in this case

which probably contributed to the formation of a ventral hernia. These were hypoproteinemia and postoperative abdominal distension.

In latent evisceration of abdominal incisions there no doubt occurs after operation an immediate but incomplete wound dehiscence. The skin remains intact over the incision but the fascial structures of the abdominal wall are separated. A herniation thus must always precede the evisceration. In the usual case the skin, being elastic, will stretch if the fascial defect and herniation become larger. All surgeons have at one time or another been impressed by huge ventral hernias in which this state of affairs had existed. It is in the most unusual case where the skin suddenly gives way producing wound evisceration months or years after operation. Mechanically this no doubt results from a sudden pulsive force of the intestinal contents transmitted through the fascial defect to the skin which lacks normal elasticity over an old operative area. This loss of elasticity is a *sine qua non* of the mechanics and leads to separation at the most vulnerable site, that is, along the line of the scar. In the above reported case the sudden increase in intra-abdominal tension produced by attempting to arise from bed was sufficient to burst the markedly attenuated skin of the hernial wall.

Prophylaxis of latent spontaneous evisceration is a simple matter. It merely involves repair of the incisional hernia defect at the earliest possible time, before an evisceration develops.

Prevention of early evisceration of abdominal wounds is another matter and although, perhaps, beyond the scope of this paper, one brief comment would seem appropriate. In patients with carcinoma, in patients having contaminated wounds or in those persons debilitated by disease the use of through and through silver or steel wire sutures, 22-gauge, allowed to remain in place 21 days, will obviate dehiscence. This technique described by Zinner and Merrill (1933)[5] should be an important part of every surgeon's armamentarium.

CONCLUSION

An unusual case of latent spontaneous evisceration through an abdominal incision is reported. Treatment and prophylaxis of this condition is discussed.

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THERE WILL BE MORE . . . .

Today doctors are living in a jet-propelled, supersonic world . . . which will not wait upon a dragged-out process to discover what we think and will be willing to do.

Unless we can FIND A MODERN WAY TO THINK AND ACT CONSTRUCTIVELY AND COLLECTIVELY WITHOUT UNNECESSARY DELAY on matters of importance there will be more programs handed to us without prior discussion.

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"Idiopathic" Orthostatic Hypotension: Report of a Case with Autopsy

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BRADBURY AND EGGLESTON[1] in 1925 reported three cases of postural hypotension associated with giddiness, weakness, syncope, loss of postural reflex pulse change, loss of potency and sweating, and certain neurological changes. These manifestations were worse in the early morning and were intensified by exposure to heat. Their patients also had a lowered basal metabolic rate, decreased output of urine in the erect position and elevation of plasma nonprotein nitrogen. Similar cases have been reported since, mostly in middle aged males. The triad of orthostatic hypotension, anhidrosis and impotence tends to distinguish the few dozen reported cases of "idiopathic" postural hypotension from the more common "secondary" orthostatic hypotension. The latter may be associated with tabes dorsalis, diabetes mellitus, parkinsonism, arteriosclerosis, Addison's disease, syringomyelia, hematomyelia, hydrocephalus, encephalomalacia, "chronic myocarditis" and some other diseases. Many cases designated "idiopathic" were not followed long enough to rule out a latent or cryptic causative factor. Several patients died suddenly; complete autopsies were performed in only a few instances. The syndrome is believed by most observers to be due to some abnormality of the hypothalamic autonomic center, although the mechanism responsible for the circulatory phenomena is in dispute. Nylin and Levander[2] suggested that the hypotension is in the nature of "asympathicotonic orthostatism".

Treatment has included a broad spectrum of pharmacologic agents and physical modalities-ephedrine, paradrine, amphetamine and corticosteroids; constricting stockings, abdominal binders and elevation of the head of the bed. "Cures" have been reported but spontaneous remissions may occur and treatment usually is directed to amelioration of symptoms. Rosecan, Glaser and Goldman[3] presented an excellent summary of the cases reported to 1952. A number of cases have been reported since[4-13]. The following case, with pathologic findings, has certain features of interest.

REPORT OF A CASE

E. M., a 41 year old married white male clerk, was first seen October 15, 1953. He complained of a "dizzy spell" while driving his car. He had had several similar attacks during the preceding four months. These were characterized by giddiness, dim vision and, occasionally, by momentary loss of consciousness. They occurred while standing or sitting and subsided quickly when he lowered his head. He felt confused briefly afterwards and had amnesia for the attack. There was no headache, vertigo, nausea, chest pain, cough, dyspnea, convulsion or hyperventilation before or after an attack.

Additional interrogation revealed gradual loss of ejaculatory power since 1949, but erections were maintained satisfactorily until 1951. Libido had continued undiminished and his impotence was a source of great distress. Love dreams still occurred but nocturnal emissions had ceased. Urinary incontinence started suddenly in 1950. Later he had urgency and dribbling during the day and nocturnal enuresis became frequent. He consulted a urologist in August 1951 and was reported to have trigonitis, urethritis and a firm, fibrous prostate gland. Function was judged

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to be normal by cystometrogram and ureteral catheterization revealed normal renal excretion, bilaterally. The plasma non-protein nitrogen was 29 mg./100 ml. These findings were unchanged a year later. He was urged to consult a psychiatrist, but refused. He used to perspire freely but this function had decreased gradually since 1951 until finally he perspired only about the hat band. He tolerated summer heat poorly and avoided exposure.

Review of Symptoms: He was distressed emotionally about his disabilities but otherwise was well adjusted mentally. There was no defect of memory or judgment, diplopia, dyssynergia, dysarthria, weakness, sensory abnormality or anal sphincter disturbance. He had no respiratory or cardiac symptoms, but complained of mild post-prandial bloating, eructations and pyrosis. His appetite was excellent and his weight had increased steadily. He slept well but had felt abnormally fatigued for many years. He smoked a pack of cigarettes and drank four to six cups of coffee and two bottles of beer daily. At one time he drank much more beer.

Past History: He had had scarlet fever, without sequelae, in 1930.

Family History: His mother died of diabetes with hypertension and coronary sclerosis; his father of bronchogenic carcinoma, coronary occlusion and myocardial infarction.

Physical Examination: He weighed 257 lbs. and was 6′3″ tall. His temperature was 98.6 degrees, his blood pressure 120/80 seated and 60/? standing. His pulse remained regular and steady at 68/minute, regardless of position or exertion. He was well developed, obese, anxious and embarrassed. His clothing smelled of urine. The face was symmetrical at rest and in motion. His tongue protruded in the midline. The left pupil was larger than the right; both were round and reacted to light and in accommodation. There was no nystagmus or diplopia and extraocular movements were performed normally. The fundi were normal, the discs of good color. Pressure upon the carotid sinuses caused no observed effects. Co-ordinated movements were executed normally. Muscle power was unimpaired, tendon reflexes active and equal. Sense of touch, position, temperature and vibratory perception was intact. The abdominal reflexes were absent; the cremasteric reflexes were equal and active. The Babinski and confirmatory signs were present on the right side. The abdominal and thoracic organs appeared normal. The pedal arteries were elastic and there was no edema of the extremities. There were no abnormalities of the thyroid gland, skin or hair. The anal sphincter was atonic. He had a small hydrocele bilaterally.

Laboratory Data: Examination of the blood revealed 12.9 grams hemoglobin/100 ml., 5,280,000 erythrocytes and 25,800 leucocytes/cu. mm., with 73% segmented neutrophils, 3% stab forms, 22% lymphocytes and 2% monocytes. Mazzini and Kolmer serologic tests were negative, as were agglutination tests for typhoid, paratyphoid, brucella and tularemia. Fasting blood sugar was 137 mg./100 ml. on one occasion, 109 mg./100 ml. on another (Folin-Wu). A standard glucose tolerance test yielded values of 155 mg., 173 mg., 155 mg. and 94 mg./100 ml., at the end of 30 minutes, 1, 2 and 3 hours, respectively. The non-protein nitrogen was 39.5 mg./100 ml. plasma. The urine showed gross pyuria and bacilluria and contained hyaline and finely granular casts. Phenolsulfonphthalein tests with ingestion of 1,000 ml. water, were performed twice. In the first test, with the patient supine, he excreted 820 ml. and 45 percent of the dye in two hours. In the second test, with the patient ambulatory, he excreted 260 ml. and 43 percent of the dye. Culture of the urine yielded coliform bacilli which were sensitive to several antibiotics. Prostatic secretions contained many leucocytes, staphylococci and Gram negative rods.

Examination of x-ray films of the chest revealed no abnormalities. The cardio-thoracic ratio was 13.5/34.5 cm. A resting electrocardiogram demonstrated a flat T wave in lead I and a slightly inverted T wave in lead VL (depressed 1mm.). The electrical position was semi-vertical. A single step Master's exercise tolerance electrocardiogram, obtained the same day, was considered normal.

Progress: Treatment consisted of 5 mg. of amphetamine sulfate, before meals. His hypotensive symptoms diminished but there was no significant change in the blood pressure. Other sympathicomimetic drugs caused symptomatic discomfort. Elastic stockings, restricted caloric intake and raising the head of the bed were refused. The pulse varied from 64 to 84/minute, though rarely exceeding 72. The rate was in-

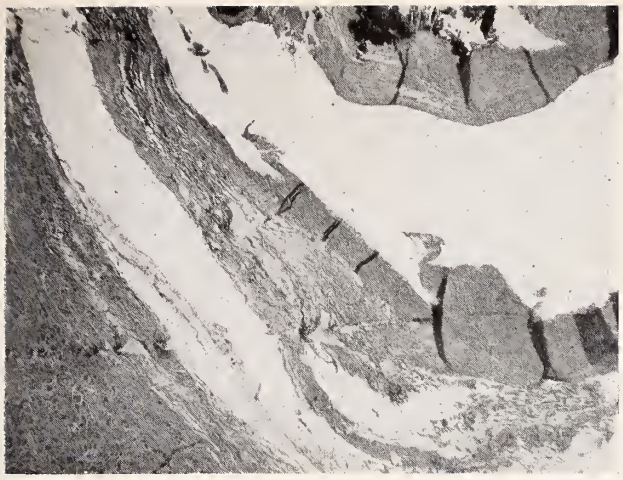


Fig. 1. Photomicrograph of coeliac axis artery and coeliac ganglion. At the top, right, is a calcified plaque, partly detached from the thickened wall of the coeliac axis artery. At the left lower corner is a portion of the coeliac ganglion. Hematoxylin and eosin stain, magnification 75 X.

creased by exertion and standing, on some occasions. The urinary infection was controlled by prostatic massage, gantrisin and oxytetracycline. His weight increased to 267 lbs. When last seen, January 24, 1954, the fatigue and unsteadiness had increased considerably. He blamed this on lack of sleep and alcoholic indulgence. The blood pressure then was 84/60 seated and 56/48 standing. The pulse, when standing, was 88—the highest recorded. He was found dead at 6 a.m., February 2, 1954, evidently after taking a shower.

REPORT OF AUTOPSY

The arterially embalmed subject appeared obese and had a massive musculo-skeletal frame, 6′3″ long. The obesity was not selective in distribution, the subcutaneous panniculus being increased generally. The internal adipose tissue was abundant but not abnormal otherwise.

The *heart* weighed 525 grams. The large coronary vessels were sclerotic and tortuous. The left circumflex artery was almost occluded by a calcified plaque. There was no evidence of infarction and the valves were not abnormal.

The *lungs* were emphysematous. The right lung weighed 625 grams, the left 600 grams.

The *liver* weighed 2,775 grams. It had yellow splotches due to lipoidosis but there was no evidence of cirrhosis.

The *kidneys* contained several old infarct scars. The left kidney had two recent, partially organized infarcts. The right kidney weighed 225 grams, the left 275 grams.

The *adrenal glands* appeared normal.

The *brain* had a normal external configuration. No lesions were found in the cerebrum, cerebellum, mid-brain, basal ganglia or ventricles, in coronal sections made serially at intervals about 1.5 to 2 cm. apart.

The *spinal cord,* removed from the 7th dorsal vertebra to the corda equina, appeared normal.

The *thoracic, splanchnic* and *lumbar* sympathetic ganglia and nerve trunks were easily identified and appeared normal, as did the vagus nerves.

Histologic examination of the brain, spinal cord and peripheral nerves revealed no significant abnormalities*. Examination of the brain included sections in the plane of the mamillary bodies, the infundibulum and its stalk. The cervical and thoracic sympathetic ganglia also appeared normal. The coeliac ganglion was not abnormal, but the coeliac axis artery had a markedly narrowed lumen due to severe atherosclerosis (Fig. 1).

The *heart* contained focal areas of fibrosis in the septum. A mural thrombus almost occluded the lumen of the left coronary artery. The right coronary contained a canalized thrombus, only slightly less obtrusive than the one in the left artery.

Sections of the *kidneys* confirmed the gross impression of severe arteriosclerotic nephropathy with old and recent infarcts.

Microscopic Diagnoses:

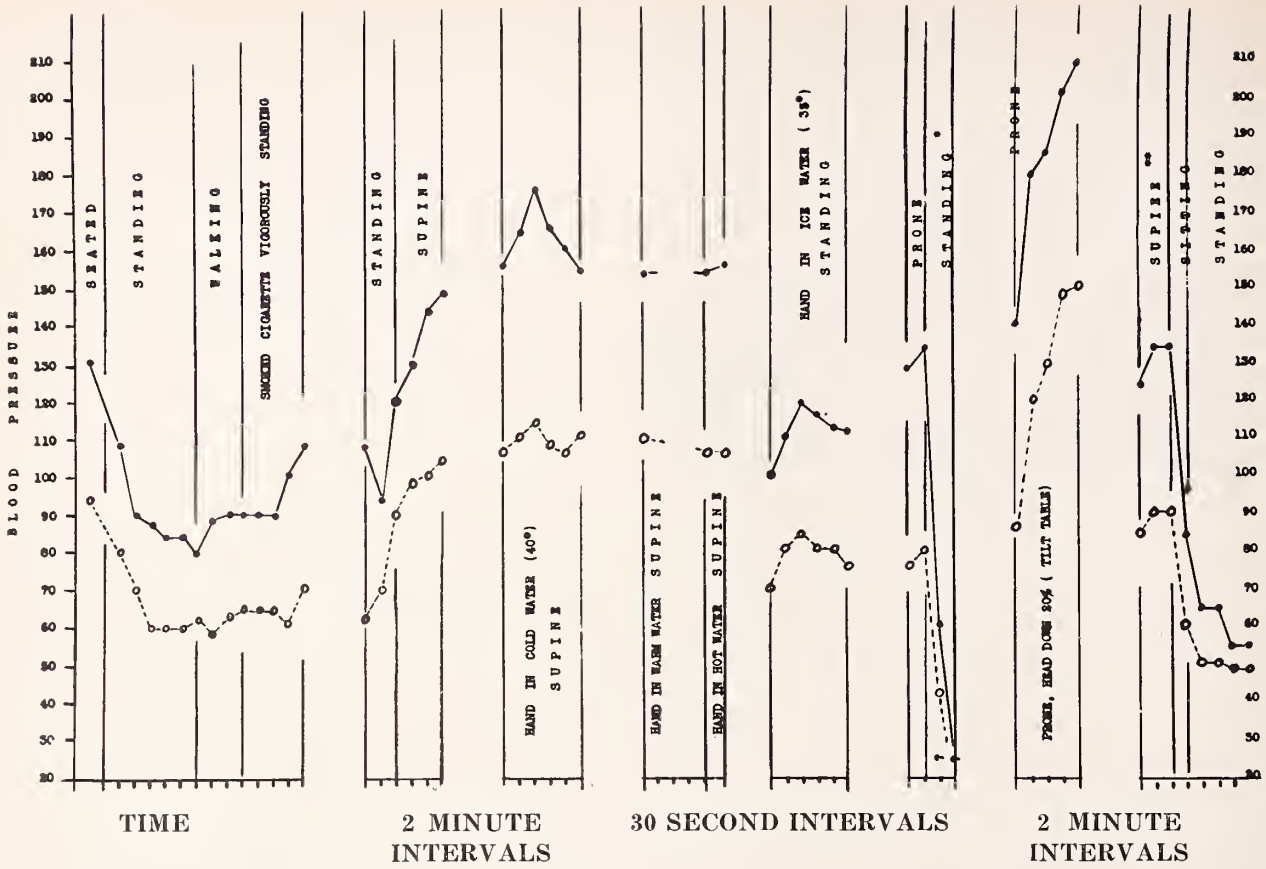
Advanced coronary atherosclerosis with thrombosis
Atherosclerosis of coeliac axis artery
Arteriosclerotic nephropathy

COMMENT

"Idiopathic" orthostatic hypotension, of the type described by East and Brigden[14], is rare. Rosecan, Glaser and Goldman[3] found 35 cases reported prior to 1952 and added two of their own. According to Benestad and Boe[4], postmortem examination, with sectioning of the brain, has been performed in only five cases, "without conclusive evidence" as to the pathogenesis of the syndrome.

Our case presented most of the cardinal fea-

* Examination of the brain, cord, cranial nerves and sympathetic nervous system was made at the Armed Forces Institute of Pathology, Washington, D. C. by Dr. Leo Krainer.



Graph 1. Composite recordings of blood pressure readings. These were made in a series of studies, intermittently, as indicated by the breaks in the base line and under varying physical conditions, as stated in the graph.

* Unsteady but conscious

** Three days ante mortem

tures of this symptom complex. It is of interest that the dizziness, which led to the correct clinical diagnosis, was one of the last symptoms to appear. It is not surprising that his initial symptoms were considered psychosomatic. Sympathetic activity was present, though reduced (Graph 1). His symptoms improved on sympathicomimetic therapy, but lack of objective change indicates that benefit was due to suggestability. The increase in blood pressure, while smoking vigorously, was unexpected and surprising. Nylin and Levander[2], who noted an increase of the blood pressure when the head was lowered, suggested that this might be due to lack of vagal activity, since normally the blood pressure falls under such conditions, due to vagal stimulation. They postulated that both the sympathetic and the parasympathetic systems are affected, a conclusion consistent with our findings and those recorded by others. They concluded that the diversity of symptoms probably is due to dysfunction of the hypothalamus—an opinion concurred in by many other observers. They suggested that venous pooling and deficient arteriolar vasoconstriction are due to a single neurogenic abnormality. It has been claimed that production of noradrenalin is decreased because of some hypothetical lesion in the region of the mid-brain[4, 5]. Our case does not support such a theory. Young[15] suggested that the pathogenesis and pathologic physiology vary in different cases. It is possible that severe narrowing of the coeliac axis artery, in our case, affected the regulation of the circulation by the coeliac ganglion. However it does not seem likely that such a localized lesion can produce the multiplicity of signs and symptoms exhibited by our patient. We were unable to demonstrate morphologic changes in the brain, spinal cord, sympathetic ganglia, vagus nerves or spinal nerves. Abnormal signs strongly suggest the presence of disease of the spinal tracts and the autonomic nervous system, however. Similar manifestations have been noted in diabetic neuropathy. Moreover, autonomic defects can be demonstrated in patients after sympathectomy[12]. "Par-

tial ganglionectomy" may have been present in our case, due to the narrowing of the coeliac axis artery. He had a family history of diabetes and some changes compatible with incipient or latent diabetes. The isolated abnormality of a Babinski sign, in our patient, is suggestive but not conclusive evidence of involvement of the central nervous system.

The prognostic significance of the abnormal electrocardiogram was not fully appreciated because of the normal exercise tolerance electrocardiogram. Additional examinations, with the patient quiet but erect, might have been of value, though some of the recorded reports were not helpful in this respect. The severe coronary sclerosis affords a satisfactory explanation for the mechanism of his sudden demise which perhaps was precipitated by a hypotensive crisis. Sclerosis of the coronary vessels is said to be rare in this syndrome[3].

SUMMARY

1. A case of "idiopathic" orthostatic hypotension, with complete autopsy, is reported.
2. There was severe atherosclerosis of the coronary, renal and coeliac axis arteries.
3. It is suggested that severe narrowing of the coeliac axis artery produced ischemia of the coeliac ganglion and precipitated attacks of orthostatic hypotension.
4. The premise that the pathogenesis varies in different cases, is accepted. Lack of demonstrable lesions in the central nervous system does not necessarily prove that none were present in this case.
5. The sudden, unexpected death of our patient indicates that the syndrome is not benign.

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Epidemic (Arthropod-Borne Viral) Encephalitis in Indiana

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ENCEPHALITIS has been observed as a serious sequalae to such common diseases as measles, mumps, and poliomyelitis; rabies and smallpox vaccine; chemical poisoning such as lead or arsenic. The term "encephalitis" in medical literature is loosely used to cover both encephalitis and encephalomyelitis. "Brain Fever and/or Sleeping Sickness" are popular terms for this illness. In the past 40 years four types of "epidemic encephalitis" have been noted in the United States. These are von Economo's disease (encephalitis lethargica or Japanese A encephalitis), eastern and western equine encephalomyelitis and St. Louis encephalitis.

Diseases manifested as viral encephalitis have been confusing when classification has been attempted. Ayres and Feemster have perhaps the best approach to this problem with their three groups; "Virus encephalitides caused by familiar viruses not ordinarily encephalitogenic; suspected, primary virus infections; and primary virus infections". The third or primary virus infection group includes eastern and western encephalomyelitis and St. Louis encephalitis. Since the work of Hammon and others indicated transmission of eastern and western equine encephalomyelitis and St. Louis encephalitis viruses to be by insect vectors, i.e., mosquitoes, mites, ticks, Hammon proposed the name for this group of "Arthropod-borne Virus Encephalitides".

The viral encephalitides in man are characterized by a sudden or gradual onset preceded by respiratory symptoms, fever and headache. In a period of 24 to 48 hours the following symptoms may be seen in varying degrees of severity: lethargy, somnolence, stupor and stiffness of the neck. In severe cases mental confusion, speech difficulties, tremors, diplopia, convulsions and coma may appear. From 20 percent to 60 percent of the cases may terminate fatally. Fatal cases usually occur among the very young or aged, but the St. Louis type causes more fatalities in the latter group. At the present time no specific vaccines or chemotherapeutic agents are known. Victims of the disease can only be treated sympathetically and with supportive care. In those cases that recover, there may be residuals due to permanent central nervous system damage.

It is reasonable to assume that any of the viral encephalitides that have occurred elsewhere in the United States might occur in Indiana. The reservoir of the viral agents causing encephalitis in the United States is avian. Both domestic and wild birds have been incriminated. Eastern and western equine encephalomyelitis and St. Louis encephalitis have been proven to occur among chickens, turkeys and pheasants. In the tristate outbreak involving Indiana, Illinois and Kentucky in the fall of 1955, a flicker killed in Kentucky was found to have been infected with St. Louis encephalitis. In addition to man, horses and mules may be accidental hosts; they exhibit clinical symptoms to eastern and western equine encephalomyelitis, but usually exhibit few or no symptoms to St. Louis virus. Bloods from horses often show a high inapparent infection rate to St. Louis. Epidemiologically the viruses causing encephalitis in man, the mosquito and the avian reservoir form a three-linked chain.

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The chain of infection is broken if the mosquito vector is destroyed.

The clinical diagnosis of encephalitis is readily made by any physician observing the infection in a patient. The specific nature of the etiological agent can be determined in a specific case of encephalitis by laboratory tests. These tests include blood studies for complement fixation antibodies and animal experimentation for neutralizing antibodies; virus isolation from birds, mosquitoes, and brain specimens from human autopsy material.

SHOULD BE REPORTED

Infectious encephalitis is a reportable disease in Indiana, though this fact is not widely known. Most cases of encephalitis reported formerly have been sequalae of other primary infections. In the last few years there have been increasing numbers of reports of "viral encephalitis", "encephalitis, unspecified", and just "encephalitis". In the light of Indiana's experience in the fall of 1955, it is possible that a wider acceptance of current laboratory techniques may show arthropod-borne virus encephalitides to be more prevalent than previously suspected.

On September 16, 1955 it was reported to the Indiana State Board of Health, that 11 cases of encephalitis of unknown etiology, but thought to be primary virus infections, had occurred in the vicinity of Fort Branch, Gibson County, Indiana. Preliminary data indicated that all 11 cases had had their onset 7-10 days prior to September 16. At the time of the report 3 of the cases had terminated fatally and 3 more patients were on the critical list not expected to live. The situation was unusual in that so many cases were being reported from the same geographical area in a brief period of time; a common source outbreak of a primary virus infection was suspected. Of unusual nature also was the fact that all 11 cases reported were past 60 years of age. Classical symptoms of encephalitis were reported, namely: headache, fever, vertigo, lethargy, mental confusion, stupor and coma. Routine blood and spinal fluid studies were non-informing. Inquiry revealed that mosquitoes were unusually prevalent in the community.

In view of the season of the year, clinical symptoms of the reported cases, and presence of mosquitoes in large numbers, it was felt that an attempt should be made to determine the etiology. Etiological agents considered in the order of their likelihood were: (1) arthropod-borne encephalitides; (2) lymphocytic choriomeningitis; (3) unclassified virus encephalitides due to ECHO viruses. Malaria and brucellosis were considered because both diseases formerly had been endemic in the area. It was planned to obtain more complete data from physicians and patients by using a standard history sheet designed to aid in accumulating as much pertinent information as possible from an epidemiological point of view.

Assignments were made to physicians, nurses and investigators to expedite the accumulation of data and laboratory specimens. The veterinarian was asked to check on illness among domestic and wild animals and to collect animal blood specimens for laboratory examination. Engineers were requested to survey the area for mosquitoes, to trap specimens for identification and virus isolation, and to submit recommendations for control. The laboratory was urged to expedite all examinations in regard to this study.

HISTORIES SIMILAR

Contact with the physicians and examination of their records confirmed the unusual incidence of encephalitis in the area. Case histories of the patients revealed two prominent facts; nearly all of the cases complained of the unusual number of mosquitoes and also the arrival of large flocks of migrant birds, presumably starlings, prior to each wave of cases. The engineers reported large numbers of mosquitoes in the area of Fort Branch.

A number of drainage ditches through Fort Branch, nearly dry except for a few stagnant pools, and a lagoon where waste water from a meat packing plant accumulated, were found to be heavily infested with larvae and adult mosquitoes. The engineers trapped several hundred mosquitoes for identification and virus isolation. The veterinarian reported no indications of unusual illness had been observed among the birds or animals of the area. In spite of the negative report, it was urged that animal specimens be collected.

Human cases continued to be reported from an ever-widening area, extending from Fort Branch like waves from a rock dropped in a quiet pool of water. After consultation the engineers recommended intensive mosquito control measures to the town officials of Fort Branch.

Due to the excellent cooperation between the town officials and the industry concerned, two fogging operations were carried out in Fort Branch and intensive oiling was done of stagnant pools. Citizens were advised and urged to utilize all known control methods, i.e., screening, spraying with insecticides, elimination of weeds and high grass around homes, elimination of refuse or other areas where pools of stagnant water might afford breeding places.

Altogether 96 cases were reported and investigated. Of these, 2 were residents of Kentucky and 6 residents of Illinois. The state health departments of these states were notified and all data accumulated on their cases forwarded to them. Eight of the remaining cases were reported too late for complete investigation and inclusion in this report. This left 80 Indiana cases accepted as reported cases of St. Louis encephalitis. Rumors of other cases in neighboring areas left little doubt that the problem was much bigger than the number of reported cases would indicate. The 80 Indiana cases were reported from Gibson, Posey, Vanderburgh, Warrick, Knox, Sullivan, Daviess and Greene counties, all in southwestern Indiana (see Table No. 1). Fifty-nine of these cases had classical symptoms of encephalitis. Positive complement fixation tests were reported on 36 of the 59, some being as high as 1:32 (see Figure 1). Neutralizing antibody tests were obtained on 12. The neutralizing antibody tests were run on blood specimens having a low complement fixation titer, but where the patients had outstanding clinical symptoms of encephalitis. The peak of the epidemic occurred the week ending September 16, 1955 (see Figure No. 1).

Autopsy specimens were sent to the laboratory for virus isolation, but studies were unsuccessful. The laboratory identified the mosquitoes captured as Culex pipiens—quinquefasciatus complex, but were unable to isolate virus from those submitted.

Out of the 59 cases with classical clinical symptoms there were 13 deaths or a case fatality of 22 per cent (see Figure No. 2). Out of the total 80 cases reported and accepted as St. Louis encephalitis there were 18 deaths which is also a case fatality rate of 22 per cent. The reported cases occurred almost 2 to 1 in females as compared to males. It was noted that most of the cases occurred among elderly residents who routinely sat in the yard or on the porch in the evening; and although they complained about the unusual number of mosquitoes were not too complaining about the bites. Forty-three of the 59 with classical symptoms occurred among those past 50 years of age (see Table No. 2). The extremes of age were 8 months and 89 years; both extremes were laboratory confirmed. Complaints of the 59 with classical symptoms were: 55 fever, 48 headache, 35

TABLE NO. 1

Reported cases

	Cases investigated	Cases clinically encephalitis	Clinical cases with lab. findings	Deaths among investigated cases	Death—clinical cases enceph.	Males	Females	Headache	Fever	Vertigo	Somnolence	Disorientation	Stupor	Coma	Lethargy	Mosquitoes	Animal contact
Gibson Co. Total	35	26	10	9	8	8	18	22	24	8	6	11	13	4	8	22	8
Fort Branch	(14)	(11)	(3)	(7)	(6)	(2)	(9)	(8)	(11)	(3)	(3)	(4)	(3)	(3)	(3)	(10)	(5)
Princeton	(16)	(11)	(5)	(1)	(1)	(3)	(8)	(11)	(9)	(4)	(2)	(5)	(7)	(1)	(4)	(8)	(2)
Gibson Co. (other)	(5)	(4)	(2)	(1)	(1)	(3)	(1)	(3)	(4)	(1)	(1)	(2)	(3)	(0)	(1)	(4)	(1)
Posey County	7	6	3	1	1	3	3	3	6	3	0	3	3	1	1	6	5
Vanderburgh County	5	2	1	2	1	1	1	2	1	2	0	2	1	2	1	2	2
Warrick County	2	2	1	0	0	2	0	2	2	1	0	1	0	1	0	2	1
Knox County	1	1	0	0	0	1	0	1	1	0	0	0	1	0	0	1	0
Sullivan County	1	1	0	0	0	0	1	1	1	0	1	1	1	1	0	1	1
Daviess County	2	2	1	0	0	0	2	2	1	0	0	1	1	1	1	1	0
Greene County	27	19	3	6	3	7	12	15	19	15	6	11	15	12	8	18	7
TOTALS	80	59	19	18	13	22	37	48	55	29	13	30	35	22	19	53	24

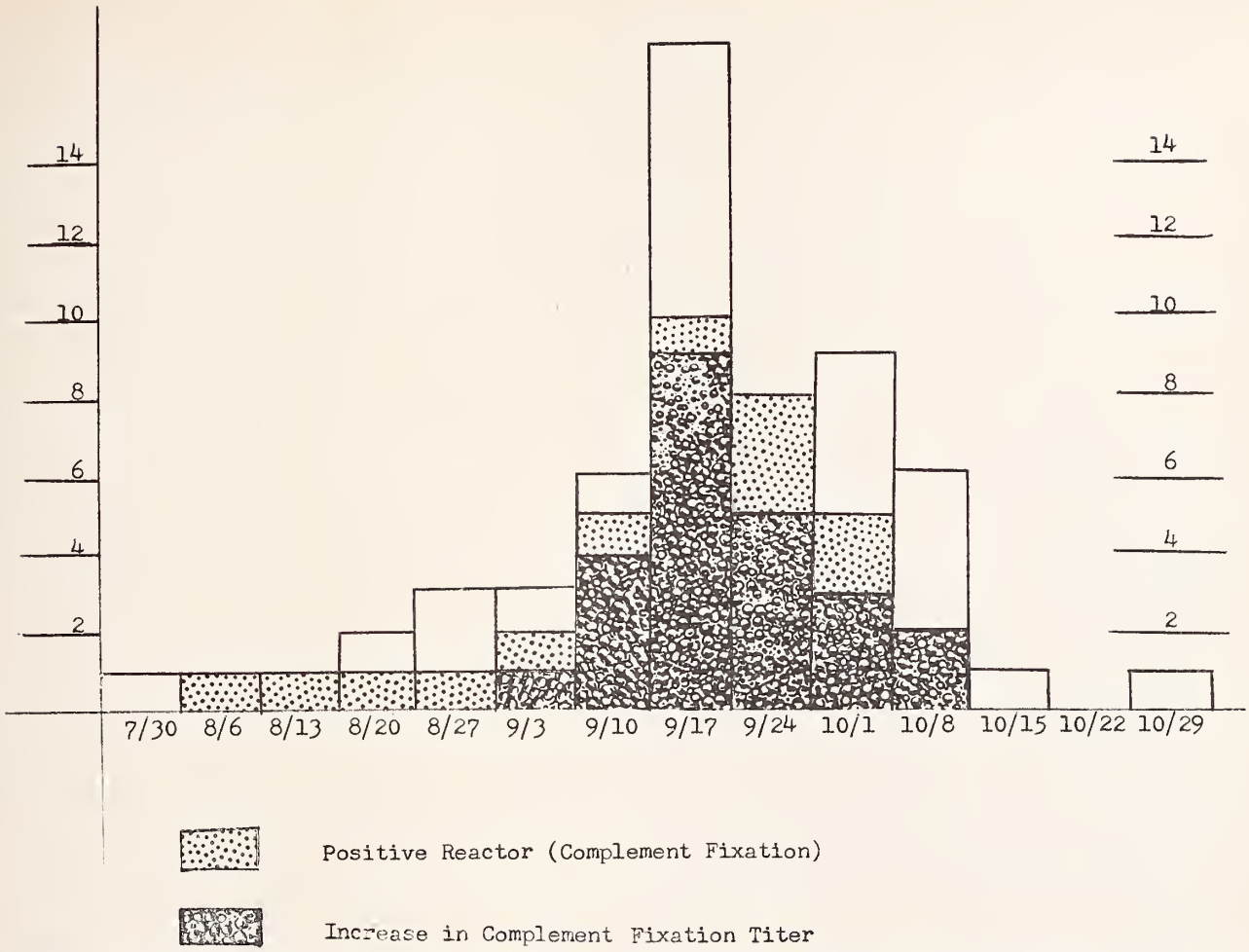

Figure 1. Onset of case with classical symptoms by end date of reporting weeks and laboratory reports.

stupor, 30 disorientation, 29 vertigo, 22 coma, 19 lethargy, and 13 somnolence.

Human laboratory specimens collected during this study included: (1) blood samples for complement fixation and neutralizing antibody studies, (2) blood smears for malarial parasites (all negative), (3) spinal fluid, blood, stools and brain tissue for virus isolation. Animal laboratory specimens included: (1) live mosquitoes for identification and virus isolation studies, (2) chicken and turkey blood for complement fixation and neutralizing antibody studies (an attempt was made to obtain blood from starlings for these studies but quantity was insufficient for examination). Attempts to obtain horse bloods were unsuccessful.

On the basis of clinical studies of cases and positive laboratory findings it was established that Indiana had an epidemic of St. Louis encephalitis, one of the arthropod-borne viral encephalitides, in the fall of 1955. Although not proven by virus isolation studies, the vector was felt to be Culex pipiens—quinquefasciatus complex, since this species of mosquito was so unusually prevalent. Kentucky and Illinois had outbreaks smaller in number at the same time in areas adjacent to the involved counties in Indiana. The Illinois and Kentucky cases were laboratory confirmed. A team from the United

Figure 2. Classical cases by age groups. Shaded areas indicate fatal cases.

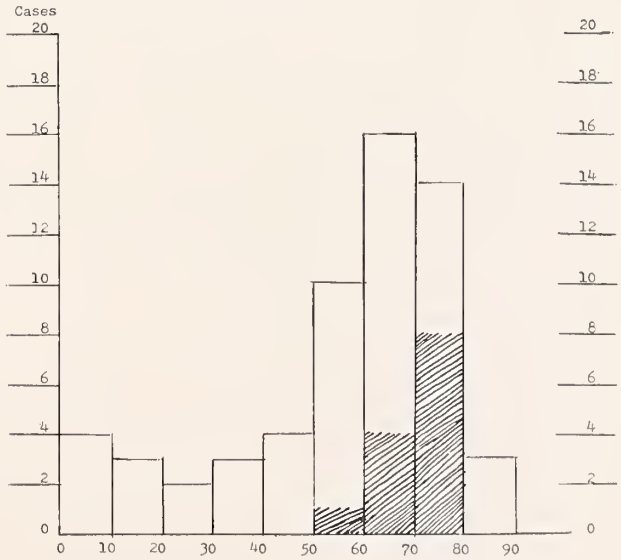

TABLE NO. 2

Age distribution of cases with classical symptoms

	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	90 +	Total Clinical Cases
Gibson Co. Total	1	1	2	2	1	2	5	10	2	0	26
Fort Branch	(0)	(0)	(0)	(1)	(0)	(1)	(3)	(5)	(1)	(0)	(11)
Princeton	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(4)	(0)	(0)	(11)
Gibson Co. (other)	(0)	(0)	(1)	(0)	(0)	(0)	(1)	(1)	(1)	(0)	(4)
Posey County	2	0	0	0	1	2	1	0	0	0	6
Vanderburgh County	0	0	0	0	0	1	1	0	0	0	2
Warrick County	0	1	0	1	0	0	0	0	0	0	2
Knox County	0	1	0	0	0	0	0	0	0	0	1
Sullivan County	0	0	0	0	0	0	1	0	0	0	1
Daviess County	0	0	0	0	0	0	1	1	0	0	2
Greene County	1	0	0	0	2	5	7	3	1	0	19
TOTALS	4	3	2	3	4	10	16	14	3	0	59

States Public Health Service working in Kentucky obtained positive blood from a mule and from a flicker. The Kentucky mosquito pools were also Culex pipiens—quinquefasciatus complex, and they likewise were negative on virus isolation.

At the date of this paper, November 15, 1956, there have been 69 cases of unspecified encephalitis reported in Indiana since January 1. Blood specimens submitted this fall have revealed many positive reports of titers 1:8, 1:16, 1:32, 1:64 and one positive in the dilution of 1:128 which is an exceptionally high positive for St. Louis encephalitis. (Titers of 1:8 and above are regarded as indicating recent infection). As of November 2, 1956, Public Health Morbidity Reports have indicated that Kentucky has had 101 reported cases (with 10 deaths) of St. Louis encephalitis in the neighborhood of Louisville. Twenty of these have been confirmed as St. Louis encephalitis by laboratory tests. Reports are pending on 41 additional cases. Seventy-three of the cases have been in females and 28 in males.

From the experience of Indiana, Illinois and Kentucky in 1955 and the more recent experience of Kentucky in 1956, it appears that there is a reservoir of St. Louis virus in some species of birds in the Ohio River Valley. The occurrence of mosquitoes as the vector and the incidence of primary cases of virus encephalitis infections in August, September and early October should make the practitioner suspicious of St. Louis encephalitis.

Colles Fractures

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THE SCARCITY of written material on Colles' fractures today implies general acceptance of treatment and end results obtained. Still, using criteria by which we evaluate results in other types of fractures, this particular injury has a greater incidence of unsatisfactory results than should be accepted. Perhaps this is due in part to the fact that few injuries enjoy the variety of treatment in as many different hands as this one. Or again, the feeling that Colles' fracture is trivial and very commonplace has lulled us into gross undertreatment of this condition. It is the purpose of this paper to correct certain of these concepts and to suggest measures for improving the results obtained.

ANATOMICAL CONSIDERATION

The wrist joint is encapsulated by a continuous broad fibrous band with firm attachments to the distal end of the radius and ulna. These are known as the volar and dorsal radio-carpal ligaments, and radial and ulnar collateral ligaments (Fig. 1). The integrity of the radio-ulnar joint is chiefly maintained by the articular disc, a triangular structure covering the head of the ulna and running from the distal margin of the ulnar notch of the radius to the base of the ulnar styloid. These structures are rarely disrupted in fractures about the wrist but play an important part in reduction and maintenance of the reduction.

Immediately adjacent to the volar radio-carpal ligament, the flexor profundus tendons and their investing sheaths are located, while the long extensor tendons occupy a similar relationship to the dorsal radio-carpal ligament. (Fig. 1) The normal wrist will reveal the tip of the radial styloid to be approximately one-half inch distal to the ulnar styloid. The articular surface of the radius has an average volar tilt of 11 degrees, and a sloping surface toward the ulna as seen in the AP view on x-ray averaging 23 degrees. In a Colles' fracture (Fig. 2), falling on the outstretched hand results in force being transmitted through the carpals to the distal end of the radius, resulting in shortening of the radius, with a complete transverse break within the distal one inch of the radius with loss of the volar tilt and radial deviation. Varying degrees of comminution, or extension of the fracture to include the articular surface of the distal end of the radius may also occur. Supination twist of the radial fragment may occur with involvement of the radio-ulnar joint. Classifying Colles' fractures as to degree of involvement, we have:

Type 1—Simple Colles' fracture with no involvement of the radial articular surface.

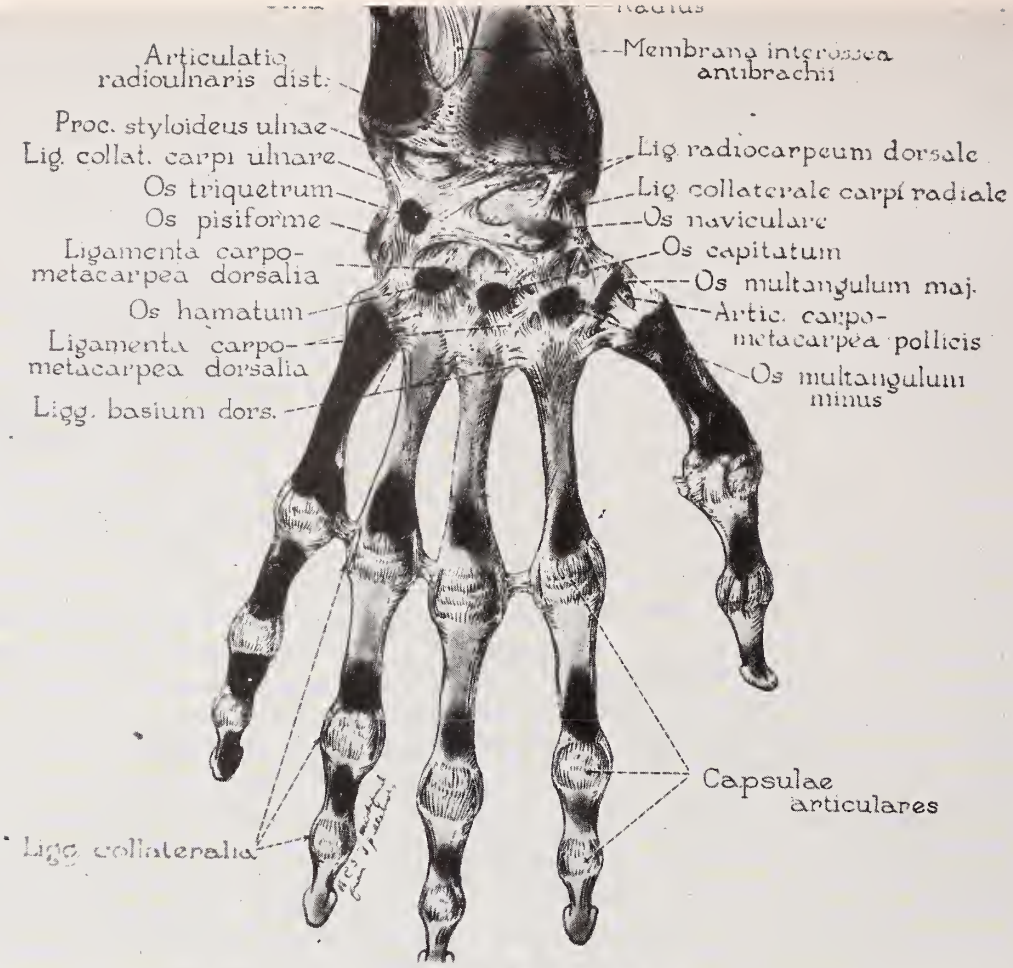
Type 2—Comminuted Colles' with fracture of the radial articular surface in which the radial fragments are not displaced.

Type 3—Comminuted Colles' with fractures of the radial articular surface in which the fragments are displaced.

This classification is important as we shall subsequently see in selection of treatment and prognosis.

TREATMENT

All treatment is aimed at restoration of the normal anatomy by correcting the radial shortening, restoring the volar tilt of the articular end of the radius, correcting the radial deviation, and supination twist if present. Local anesthesia


Articulatio radioulnaris dist.
Proc. styloideus ulnae
Lig. collat. carpi ulnare
Os triquetrum
Os pisiforme
Ligamenta carpo-metacarpea dorsalia
Os hamatum
Ligamenta carpo-metacarpea dorsalia
Ligg. basium dors.
Membrana interossea antibrachii
Lig. radiocarpeum dorsale
Lig. collaterale carpi radiale
Os naviculare
Os capitatum
Os multangulum maj.
Artic. carpo-metacarpea pollicis
Os multangulum minus
Capsulae articulares
Ligg. collateralia

Radius
Memb. interossea antibrachii
Ulna
Artic radioulnaris dist.
Proc. styloideus ulnae
Os lunatum
Lig. collaterale
Os pisiforme
Lig. pisohamatum
Lig. pisometacarpeum
Hamulus ossis hamati
Lig. hamatometacarpeum
Lig radiocarpeum volare
Lig collaterale
Tuberc. ossis navicularis
Articulatio carpometacarpea pollicis
Os capitum and lig. carpi radiatum
Lig carpometacarpeum volare
Ligg. basium volaria
Ligg. accessoria volaria
Ligg. collateralia
Capsula articularis
Ligg. capitulorum transversa

Figure 2

is practical in the comminuted fracture by injecting 10 cc. of one percent novacaine directly into the fracture site; however, general anesthesia is more widely used and acceptable. Manipulation to disimpact the fracture may be necessary, but must include traction and countertraction to restore length of the radius, and molding of the distal fragment volarwards and toward the ulna before anatomical alignment is restored. Reduction can be considered complete only after a check has been made to see that the distal radio-ulnar joint has been restored. Testing for restoration of this joint is accomplished by passively supinating and pronating the wrist in its reduced position prior to immobilization.

Immobilization is intended to maintain the restored anatomical relationship of the radial and ulnar fragments until healing has occurred. Regardless of the type of immobilization selected, it must include adequate purchase or support of the proximal and distal fragments and adequate control of the hand, inasmuch as it is only by controlling the hand that proper forces can be exerted upon the intact capsular ligaments, and, through these, obtaining proper fixation. The conventional plaster cast is still the best vehicle. When properly applied, the cast should stop short of the distal palmar crease, and the knuckles on the dorsum of the hand. Unless skeletal fixation by means of wires is used to engage the forearm, thus preventing rotary movement of the proximal fragment, immobilization must extend above the elbow. Immobilization must remain continuous and uninterrupted until such time as x-ray and clinical evidence prove that healing of the fracture is complete. The usual length of healing time is eight weeks, but four weeks to four months may be required, depending upon the particular fracture. It is often necessary to make plaster changes where early swelling has subsided, but any change in position of the wrist or extremity is to be avoided until healing has been completed—if anatomical alignment is to be preserved.

In a reported 18-month, end-result study of 60 cases of Colles' fracture treated by using

← Figure 1.

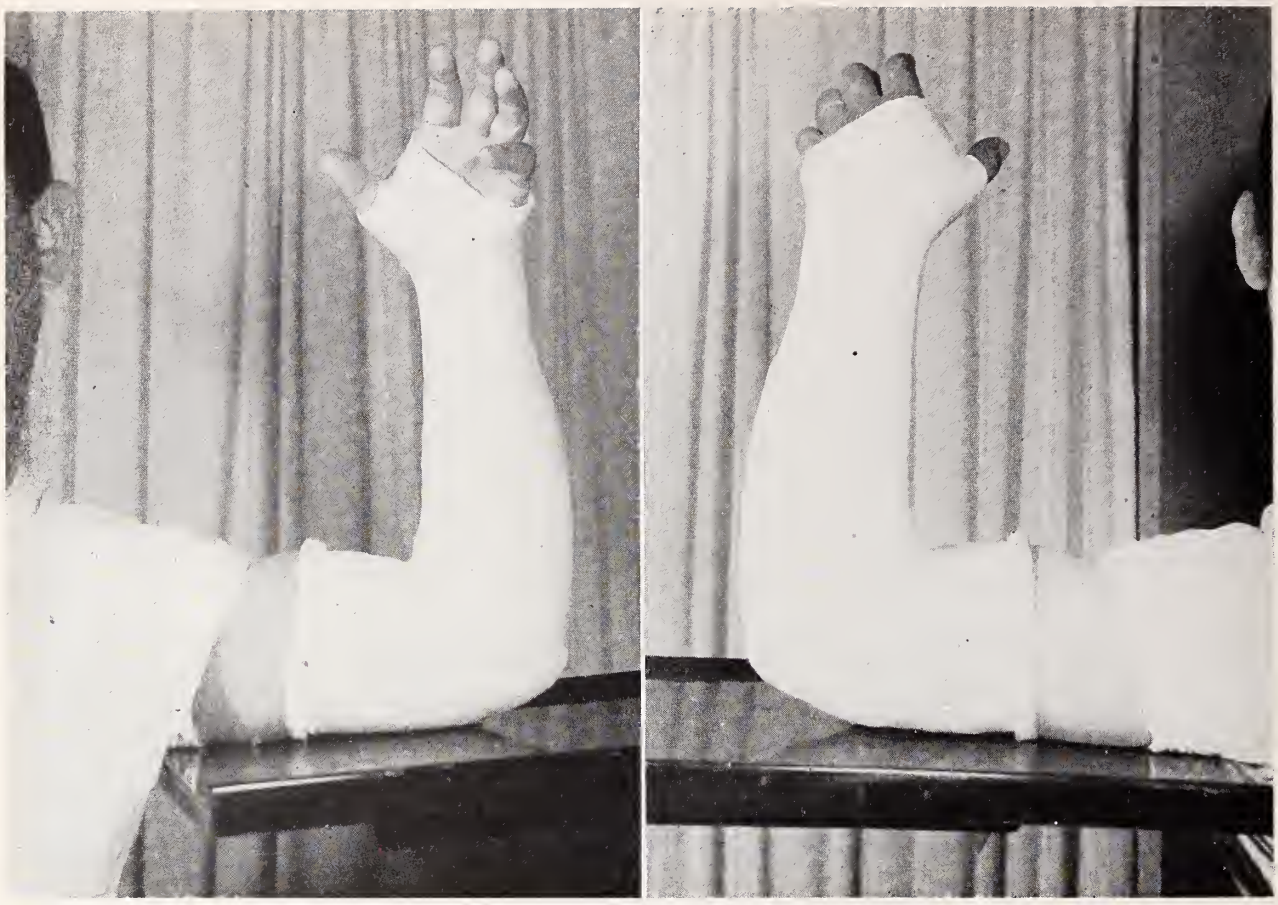


Figure 3.

the anterior-posterior molded plaster splint extending from below the elbow to the hand, 60 percent of these cases revealed a fracture healed in a position typical of a fresh, unreduced Colles' fracture. Of these, all had bony deformities about the wrist. Thirty-one percent of the total cases studied were considered as unsatisfactory results. Even with early, perfect reduction, it is obvious that use of an anterior-posterior molded plaster splint represents inadequate immobilization and cannot be recommended. The study further showed that a residual dorsal tilt of five degrees or more, and loss of three millimeters or more of length of radius was concommitant with poor functional results. In this series, lack of adequate immobilization was believed to be the most important factor responsible for residual deformities and poor functional results. This study also disclosed that immobilization for six weeks does not preclude redisplacement of the fragments. The sugar-tong splint does limit rotation of the forearm by including the elbow joint, but still utilizes the splint principle and must be attended by similar results. The simple Colles' (Type 1) may provide the exception, but statistical proof is not available from this particular study.

The conventional circular plaster cast (Fig. 3), extending from above the elbow to the knuckles of the hand, when well-applied, is undoubtedly satisfactory when the simple and uncomplicated Colles' are treated, provided undue swelling at the time of reduction is not present, and when sufficient wrist flexion and ulnar deviation are maintained until healing has occurred. In treating the more comminuted fractures using the circular plaster cast, it is important to utilize the potential of force on the distal fragment transmitted through the thumb and its adjacent capsular structures at the wrist. This may be done by including the thumb in the plaster cast, or by applying traction to the thumb using skin or pulp-type traction to a wire loop or banjo incorporated in the cast (Fig. 4). Traction through the thumb, however, is best reserved for those cases where gross comminution, swelling or fear of radial shortening alone exists, and where the radial articular surface is not grossly disrupted.

In Type 3 Colles' fracture, or when satisfac-

Figure 4.

Figure 5.

tory reduction cannot be otherwise maintained, skeletal fixation (Fig. 5) is necessary. We have employed the Roger Anderson traction device using a 3/32-inch wire driven through the metacarpals distally, through the radius and ulna proximally, and incorporated in plaster for the treatment of this type of fracture. The case illustrated was a complete failure after three attempts at manipulation and simple cast application, and after a fourth attempt using five pounds of traction through the thumb. In our opinion no treatment other than reduction and skeletal fixation could have effected a satisfactory result. In spite of adequate reduction, a post-traumatic arthritis interfering with a good result is quite likely, but should be minimized by obtaining and holding as normal a restoration of the fragments as possible. In this connection the aforementioned study revealed that Colles' fractures with gross involvement of the articular surface developed traumatic arthritis in 24.5 percent of the cases evaluated. However, this case (Fig. 5), now followed for 15 months, has normal function and shows no evidence of arthritic change.

Recently a method for treatment of the Type 2 or 3 Colles' fracture, utilizing a threaded wire driven obliquely and distally through the lower ulna radialwards to engage the radial styloid, has been described. This technique is not recommended because of the numerous complications which may arise, and because of the need for extreme skill and judgment in its application. This method, utilizing purchase on the larger fragment of the radial styloid alone, cannot control other fragments or radial-carpal alignment. Where this procedure may seem indicated, fixed skeletal traction through metacarpals and proximal radius and ulna, is much the simpler and preferred procedure.

To prevent the complication of frozen shoulder the constant use of a sling is discouraged. Pendulum exercises and repeated effort by the patient to place the hand behind the head and behind the lower back several times daily are encouraged; however, a definite point should be made to encourage early elevation of the hand within the first days subsequent to injury and treatment where swelling exists or until this factor is under control. Finger exercises and use of the affected hand for all possible acts within the limitations imposed by the plaster cast should also be encouraged from the first. If these simple instructions are carried out, complications will be avoided and the fractured wrist

will regain its motion and usefulness within a very short time after immobilization has been concluded.

A study of 2,000 cases of Colles' fracture through the New York State Compensation Board has been reported, representing the most searching study of end results from all types of treatment yet published. Some of the findings are listed below:

(1) Colles' fracture constituted 60 percent of all fractures involving the radius.

(2) The incidence of Colles' fracture among all Workmen's Compensation cases in 1945 and 1949 was one percent.

(3) A fracture of the navicular associated with Colles' fracture occurred in only 10 instances. This is indeed unusual when one considers that Colles' fracture in nearly all instances is produced by falling on the outstretched hand with the force being transmitted through the carpals to the distal end of the radius.

(4) The instance of compound Colles' fracture was 1.3 percent of all cases.

(5) Reduction was performed in 88.3 percent of the total, and of this number 3.7 percent were manipulated a second time, 1.0 percent required a third manipulation, and in only 1.6 percent was open reduction performed. 11.7 percent had no reduction attempted.

(6) The average duration of treatment per case was four months.

(7) Physical therapy was used in 96.6 percent of the cases and appeared to have little influence on the results obtained.

(8) Only 62 cases were judged to have no permanent disability. The average disability was 24 percent loss of function of the hand in the total series.

(9) The percentage of disability increased at the rate of four percent loss of function for each decade of age per patient.

(10) The residual deformity was graded as none, mild, moderate and severe. For each degree of deformity, disability was found to increase 10 percent.

(11) The most frequent defect in passive motion about the wrist was in palmar flexion (94.5 percent of the cases), and a defect in dorsiflexion was found in 80 percent of the cases. Limitation of rotation of the forearm was found in ⅓ of all cases, and limitation of lateral wrist motion was found in 50 percent of the cases.

(12) Forty-eight percent of all cases showed restriction of motion of the digit (limitation in flexion was two times as frequent as extension). The distal interphalangeal joints were most often afflicted, with the index finger the most frequently involved and the thumb the least involved digit.

(13) One-third of all cases revealed some loss of grip.

(14) Non-union was found in 4 cases, delayed union in 14 cases, traumatic neuritis of the median nerve, 4 cases, ulnar nerve, 1 case, Sudeck's atrophy, 3 cases, Dupuytren's contracture, 4 cases, persistent pain, 2.0 percent, limitation of shoulder motion, 20 cases, concommitant navicular fracture, 10 cases.

(15) Fifty-three percent of all cases were accompanied by an avulsion fracture of the ulnar styloid of which one-fourth remained ununited.

DISCUSSION

The above report definitely confirms our everyday experience that Colles' fracture, whether associated with industry or not, is an extremely common and exacting fracture. A report in disability of 24 percent loss of function of the hand appears unusually high in comparison to our own results in the handling of this type of fracture. Perhaps this may be due in part to the reported 11.7 percent which received no attempt at reduction of the fracture. The fact that repeated manipulations were necessary in a certain percentage and a consideration of an increase of 10 percent disability associated with each grade of residual deformity further implies that Colles' fracture treated on the average indicates no alteration of treatment in accordance with the severity of the original injury. Our

personal experience indicates that there should be no need for residual deformity when type of treatment is altered commensurate to the severity of the case. We do concur in a tendency for post-traumatic arthritic changes occurring with advancing years. The above report also confirms our feeling that physical therapy in itself has no direct bearing on the end result obtained. In this connection it would seem that co-operation of the patient in carrying out the exercises recommended elsewhere in this discussion is sufficient to prevent the complications of frozen shoulder or stiffness of the hand and fingers.

CONCLUSIONS

(1) Colles' fracture is not the trivial injury we formerly believed but one that carries with it an abnormally high residual permanent disability.

(2) The amount of residual disability is in direct proportion to the severity of the injury, the adequacy of reduction, the degree of immobilization and the age of the patient. Of these factors, proper immobilization is by far the most important, although shoulder and finger exercises and early elevation of the hand are essential in eliminating associated disability due to frozen shoulder or stiffness and swelling in the hand and fingers.

(3) Simple Colles' (Type 1) are best managed by adequate reduction and the application of a well-fitting circular cast extending from above the elbow to the metacarpophalangeal joints of the hand, with the hand maintained in moderate volar flexion and ulnar deviation.

(4) In the more severe Colles', traction should be applied to the thumb where the chief concern is loss of length of the radius.

(5) Fixed skeletal traction, using a wire through the metacarpals and proximal radius and ulna and incorporated in a circular plaster cast extending from below or above the elbow to the metacarpophalangeal joints of the hand, provides the most absolute fixation in the severely-comminuted Colles' fracture, and where early swelling would otherwise cause loss of alignment with other types of immobilization. It should be emphasized, however, that this type of treatment is used only where other means cannot maintain proper reduction of the fracture.

(6) In certain selected cases, a threaded wire driven obliquely through the ulna to engage the tip of the radial styloid is an adequate means of maintaining reduction and fixation along with application of a circular plaster cast.

It is hoped that this paper will encourage proper early evaluation of Colles' fractures; and, toward that end, we have attempted to show that Colles' fracture is not the trivial injury it is generally assumed to be, but rather one which requires selective and exacting treatment in accordance with the severity of the original injury if best results are to be obtained. Further in this regard, we have presented a study of present methods of treatment, and have proposed various types of immobilization applicable to the various types of Colles' fractures, placing special emphasis on avoiding the complications of frozen shoulder or swelling and stiffness of the hand and fingers, with the purpose in mind of influencing reduction in the disability resulting from Colles' fracture to a figure consistent with, and accepted in, the management of other types of fractures.

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GOLDEN ANNIVERSARY ISSUE

WITH THIS ISSUE The JOURNAL is entering its 50th year of publication. Volume 1, Number 1 appeared on January 15, 1908, and ushered in a series of monthly issues which has continued now for half a century. This special number is designed to commemorate the founding of The JOURNAL and to celebrate its golden anniversary.

During its first year The JOURNAL published many original contributions. The lead article written by Dr. David C. Peyton, President of the Association, is reproduced as an example of what would have been written for the "President's Page" if such a feature had been included in those days. The sentiments and ideals expressed are still valid and can be read with profit by physicians of today.

Papers by Dr. Jane Ketcham and Dr. Goethe Link were a part of the first volume. Both of these doctors are still actively engaged in practice. The JOURNAL has requested each of them to write of their reminiscences, and is pleased to include these in this anniversary issue.

FOUNDING OF THE JOURNAL

TWO YEARS of careful planning by the Council and a poll of all the county societies preceded the appearance of Vol. 1, No. 1, of The JOURNAL of the Indiana State Medical Association in January 1908.

On October 15, 1907, a special meeting of the Council was held to hear a report of a committee on the question of replacing the publication of the bound volume of "Transactions" with a monthly medical journal. Up to that date 63 of the county societies had voted for the establishment of a journal, and 8 societies had indicated a preference for a continuation of the "Transactions".

Other state medical associations had furnished the committee with information on printing costs, advertising revenue and publication policies, and had indicated complete satisfaction with their own adventures into the journal publication field. Preliminary bids on the cost of printing were presented for consideration.

The bound "Transactions" had formerly been costing about 75 cents per member each year, and it was determined that if this amount was set aside from the state dues, and added to a conservatively estimated amount of advertising income, a presentable journal could be published.

The Council then, in a series of motions, decided to publish The JOURNAL, named it The JOURNAL of the Indiana State Medical Association, and elected Dr. Albert E. Bulson, Jr., of Fort Wayne as its editor.

Dr. Bulson was authorized to employ professional and secretarial assistance, with the understanding that all salaries were to be paid from journal income. Advertising was limited to U.S.P. and N.F. preparations and to products which had approval of the A.M.A. Council on Pharmacy and Chemistry. Advertising rates were set to compare favorably with the rates of similar journals of the same size and circulation.

Further specifications decided at this meeting were that the new journal was to be of general interest to the medical profession of Indiana, and that it was to be published under the direction of the Council.

The office of publication was originally in Fort Wayne, Indiana. Dr. Bulson held the title of Editor and Manager, and Dr. Ben P. Weaver was selected as Assistant Editor.

The new journal appeared on time, in January, 1908. It was a vigorous infant and under the energetic editorship of Dr. Bulson, it made its own way financially. It is now a matter of history that it has continued on the same course upon which it was so wisely launched. It now enters its 50th year having grown and prospered since that time long ago.

It is remarkable that it has continued essentially on the same set of principles and administrative policies which were adopted for its inauguration at a single meeting of the Council in October, 1907.

The Council to which The JOURNAL owes its founding was composed of:

W. R. Davidson, Evansville, First District

George Knapp, Vincennes, Second District

Walter J. Leach, New Albany, Third District

W. H. Stemm, North Vernon, Fourth District

Joseph H. Weinstein, Terre Haute, Fifth District

D. W. Stevenson, Richmond, Sixth District

W. N. Wishard, Indianapolis, Seventh District

G. W. H. Kemper, Muncie, Eighth District

George Rowland, Covington, Ninth District

E. G. Blinks, Michigan City, Tenth District

Charles H. McCully, Logansport, Eleventh District

Albert E. Bulson, Jr., Fort Wayne, Twelfth District

C. A. Daugherty, South Bend, Thirteenth District

W. N. Wishard was Chairman, and A. E. Bulson was Secretary.

WE CONGRATULATE SOME CONTEMPORARIES

THE YEAR 1908 witnessed the founding of several enterprises other than The JOURNAL.

Indiana University School of Medicine was formed by the union of the Medical School of Indiana which had been a part of Purdue University and the State College of Physicians. This was a part of the trend of that time to eliminate smaller schools and place medical education under university standards and guidance. The state of Indiana was complimented by many medical educators for having concentrated its teaching resources in one place and under one administration.

The American Medical Association announced the first number of the Archives of Internal Medicine. This journal was established for publication of articles relating to internal medicine which were not too technical or too elaborate for a journal of general circulation. The original editorial board was composed of Joseph L. Miller, Chicago; David L. Edsall, Philadelphia; Richard C. Cabot, Boston; Theodore C. Janeway, New York City; George Dock, Ann Arbor; and W. S. Thayer, Baltimore. The subscription price at that time was $4.00 per year, with a $1.00 discount to subscribers to the J.A.M.A.

The Methodist Hospital of Indianapolis, with the expectation of completing its first building project during 1908, held an open house in the partially completed structure on New Year's Day. Over 6,000 persons visited the hospital on that day. Hospital finances were much the same then as now. Contributions amounting to $3,600 were received during the day to assist in completion of the building.

The Rockefeller Institute for Medical Research, which had been founded six years before, received its initial endowment of $2,600,000 from John D. Rockefeller. Comment of the time was: "This gift will insure the continuance and enlargement of the institution itself and provide support for scientists engaged for it in medical research in all parts of the world".

The JOURNAL salutes these contemporary medical institutions and wishes to join them in celebration of their golden anniversaries.

THE AUTOMOBILE FOR THE DOCTOR

THE AUTOMOBILE has been around a little longer than has The JOURNAL but, as evidenced by the following editorial reprinted from the April 1908 issue under the above title, the two of them could be said to have grown up together.

"The Journal of the American Medical Association for March 7, 1908, very properly devotes a number of pages to the subject of the automobile as a conveyance for physicians. As might be expected, not all of the contributors to the pages devoted to opinions from physicians are of the same mind as to the value of the automobile for the doctor, but the general verdict is favorable. As a vehicle for use the year around the use of the automobile is confined principally to cities having well paved streets. For ordinary country roads the automobile is adapted to summer months only. But even for limited use the automobile, on account of the saving in time, is a practical conveyance for the doctor to own. Very dependable cars are now made which cost less than $1,000, and several well-known makes cost $500 or less. The trouble and expense arising from the use of a car depends very largely upon the operator, though to some extent upon the conditions under which the car is operated. However, two men owning cars of the same make and pattern and operating them over the same roads and for the same length of time may have entirely different results as to trouble and expense, all depending upon the manner in which the cars are used. An automobile is in many respects like a horse; it must have some kind of care and be driven judiciously. If so handled it will give the user general satisfaction by proving economical, time saving, and a source of pleasure. Any well known make of car will do this now."

Guest Editorials:

A DOCTOR IS FIRST A HUMAN BEING

Reprinted from the North Carolina Medical Journal, October 1956, where it appeared as the President's Message over the signature of Donald B. Koonce, M.D., Wilmington, North Carolina.

MUCH HAS BEEN SAID recently about the practice of the humanities of medicine. There is nothing complicated about this practice. It is simply the practice of a doctor remembering that he is a human being ministering to other human beings and treating his patients in the manner that he would like to be treated were he in that patient's place.

It sometimes happens that a doctor begins to feel that he is a little different from other people and has more godlike qualities than the average man. That doctor is doomed to frustration and unhappiness and his patients to disillusionment. A doctor does not and should not have any godlike powers in the giving and taking of life. He has simply allowed himself to be trained so that, with the help of God, in many instances he may save life and preserve the physical integrity of the human body. A doctor is privileged to be so closely associated with life and death that it is difficult to see how one could ever question the power of God.

It is understandable how too frequently a patient attributes godlike qualities to his doctor. This is understandable because a doctor who practices the humanities of medicine is not just a doctor of medicine. He is a healer of the sick, both physically and mentally, a father confessor, and a beloved friend in the time of need. That patient who attributes divine powers to his doctor is also doomed to disappointment and disillusionment. His doctor is still a very human being and made of clay. He has no supernatural physical abilities which would allow him to work day and night without rest or to be readily available each and every time that patients may need him. He does not have the divine ability always to make unerring decisions and always to give the right advice. He is not immune to human frailties and weaknesses and he has no unnatural ability to resist the temptations of life any more than any other man. He does not have the power, without God's direction, to perform the seeming miracles attributed to him. He must be strong, and yet he cannot help but be humanly weak. He must be dependable, and yet he must have many failures. He must be human, and yet he must even be more lovable.

—*Donald B. Koonce, M.D.*

ON READING A MEDICAL PAPER

MEDICAL SOCIETIES are in a most luxuriant phase; more meetings are being held than ever before. In many metropolitan areas, a little determination can place a physician in at least one scientific meeting a day. With this accelerated state has come increased opportunities for presenting medical observations to fellow doctors, i. e., reading a medical paper.

It has been my feeling that the technique of this significant activity has not received enough attention. One reason is that the audience is largely inarticulate, at least beyond the formality of applause. As a frequent member of this medical audience, I would like to record some thoughts I have had on reading papers. These are personal views, but I have reason to believe

they may be commonly held, although infrequently expressed.

The first thing I plead is that I not be overwhelmed by an avalanche of data, observations, and ideas. Many speakers simply crush the average listener with literally hundreds of new facts, all carefully posted on slides. The listener refusing to operate on a Univac level turns off his motors and moves over to a pleasant autistic realm.

The pernicious habit of presenting techniques and detailed data appears to have developed because man is capable of reading aloud at a rate of 200 words per minute. This permits the speaker, if he reads a manuscript, to release the bulk of his findings to the audience. With the use of slides hundreds of numerical figures can be added. All in all, it is a fine *tour de force,* but it often leaves the audience exhausted yet uninformed, or worse, indifferent to the speech.

I would urge that medical talks be talks. As such, they can effectively transmit ideas and leave the audience informed and stimulated. I have long noted how a colleague can enthrall you with his experiences as recounted over the hospital dining room table, yet these same experiences are boring when read as a formalized paper in staff conference. The need to be scientific and precise can at times have a most deadening influence.

Speakers should recognize that the audience is their friend. Give a friendly narrative account, therefore. Remember, no one can truly evaluate your findings on the basis of a talk. He must turn to the published paper for the detailed prolonged study of methodology and data. The short speech serves solely to transmit your singular idea on the topic. The longer speech should be used to present a broader concept or scheme of things rather than the showy display of even more data in depth.

Be sympathetic to the fact that the live audience has no real power to skim or skip, so that the speech should be a significant one. Too often speakers request or accept program time for the presentation of data which is better never presented verbally. I refer to the negative finding, the reference data of interest to very few, and finally to the "ectopic paper" floundering before the wrong society. A brilliant address on backgammon will be poorly received by the philatelic society, although clever titling may win it a place on the program.

I will count myself fortunate at the next meeting I attend if at least one of the speakers talks as one who wants me to know and to feel the native simplicity of his particular idea. The idea should take precedence over the smothering data, oratory, and elegant phrasing which so often accompany the reading of a paper.

—*Walter B. Shelley, M.D.,*
in Pennsylvania Medical Journal

THE NEW LEISURE

The huge increase in leisure time will itself create giant new industries which cater to that need, but it will also create the serious problems that already flow from leisure. There are hundreds of thousands of people who push 220 horsepower instruments down the highways of America who still are not emotionally equipped to drive anything larger than a kiddy-car. There are people today with hours and weeks of leisure time at their disposal who are not equipped to spend five minutes in their own presence, let alone the presence of their families. The rush to get out on the road on a sunny weekend is, in many cases, the rush to get out of the house, away from the same old walls, the tired old faces, and the hateful old environment; increasingly, it leads only to the frustration of winding up, bumper-to-bumper, in a line which seemingly starts nowhere and ends nowhere except in further frustration. The problem of leisure is one which also has reflected itself in a variety of social statistics that we know separately as juvenile delinquency, divorce, mental illness. Happily, in this age of technology and science, as some of the problems grow larger, solutions are developing. Just five years ago it seemed probable that there would be no possibility of even housing the potential recruits for the mental hospitals of the nation ,much less giving them adequate care. At this moment they are all but bursting the walls of the mental hospitals to make room for those who require services. Yet, at this very same moment, an ancient remedy now being manufactured in refined form by American drug companies—derivative of the Indian snakeroot—has already revolutionized the practice of psychiatry and has in a number of instances emptied as much as half of an entire mental hospital within a matter of weeks.

—From "New Challenges for American Business Leadership," by Leo M. Cherne, Executive Director, Research Institute of America; Address given before the California Personnel Management Association, Berkeley.

The President's Page

LET FREEDOM RING

THE NEW YEAR and the convening of a new Congress poses a situation of timely interest and import to every one. The particular question in mind is the spread of Socialism in the world and especially in our own country, where it is making insidious and often more obvious inroads into our business, habits, homes, yes,—even our very existence. We no longer speak of the danger of Socialized Medicine; that is only a part of the greater and more widespread danger, that of Socialism. This in turn is only a step removed from Communism, if not in fact synonymous with it. At least the word is so used in Russia, whose official designation, U.S.S.R., means Union of Soviet Socialist Republics—no reference there to Communism, is there?

Undoubtedly, there will come before the new Congress many types of fringe legislation, which will have a socialistic tinge, or will tend in that direction. We do not expect a frontal attack bringing out a proposal for National Compulsory Health Insurance, but Re-insurance is very likely to be proposed again accompanied by the specious claim that it is in fact not socialistic. A practical certainty in this session, so they tell us in Washington, is a health insurance plan to cover all Federal employees, taking another large group of persons out of the ranks of possible unattached patients, and still further restricting the free practice of medicine.

Owing to the fact that we are opposed to so many bills that come before the Congress, and write or telegraph our law-makers to vote against this or that bill, we are often placed in a negative or "agin-it" position, which I am sure we neither wish nor deserve. One proposal of a positive nature which we can all get behind with a clear conscience is the Bricker amendment, whose purpose is to prevent treaties, international covenants, or rules of the United Nations taking precedence over our United States Constitution. To begin with, it would not be a bad plan if a great many of us would start the ball rolling by writing or wiring Sen. John W. Bricker of Ohio to be sure to re-introduce his amendment. We might even start a petition to that effect.

Legislative proposals which we should scrutinize most closely are such things as widespread insurance or relief measures, unsound pension propositions, changes in the Social Security Law, welfare proposals, further extension of

bureaucracies, unlimited foreign aid, along with too much strengthening of the United Nations and consequent weakening of our own governmental structure. I do not mean that we should necessarily be against all these proposals, but in these fields the dangerous trends are most apt to rear their ugly heads, and we can be watching them. John Philpot Curran expressed the idea in 1790, when he said,—"It is the common fate of the indolent to see their rights become a prey to the active. The condition upon which God hath given liberty to man is eternal vigilance; which condition if he break, servitude is at once the consequence of his crime and the punishment of his guilt."

This is commonly quoted as "Eternal vigilance is the price of liberty", but the entire passage deserves quoting in this connection.

In conclusion, and partly because his birthday comes in this month, may I cite a reference to that dean of American statesmen in the formative days of our country, Benjamin Franklin. The story goes that the debate was on in Constitution Hall in Philadelphia, and crowds were waiting out in front to see what the decision would be. When Benjamin Franklin came out of the building, some of those in waiting approached him with the question,—"What kind of government are we to have, Mr. Franklin?", to which the sage replied,—"A Republic, if you can keep it." That question with a big IF is still with us. How shall we answer it?

Elton R. Clarke, M.D.

Nothing that was worthy in the past departs; no truth or goodness realized by man ever dies, or can die; but is all still here, and, recognized or not, lives and works through endless changes.
—Thomas Carlyle

The JOURNAL Has Lived in an Era of Change and of Unequalled Progress

FRANK B. RAMSEY, M.D.
Indianapolis

THE JOURNAL of the Indiana State Medical Association has spanned a period in medical history which has seen more discoveries and advancements than any similar period previously, and possibly has witnessed more change in scientific medicine than occurred in all recorded history before it.

In spite of this the issues for the year 1908 still make good reading, and, at least in so far as their basic subject matter is concerned, might yet be read with profit by the doctors of today.

The early issues of The JOURNAL are an interesting display of the economic surroundings and materia medica of the days of long ago. Woven through such an ancient tapestry and highlighted against it, however, one finds that the ideals of the medical profession are clearly indicated. In this respect medical literature has been changeless.

The advertisements and other references in Volume 1 are indicative of a tremendous alteration in drugs, instruments and in the economic life of the country. Frequent references to problems such as worthless nostrums, traveling quack doctors and unlicensed practitioners tend to show that, while these vexations are still with us to some extent, they required much more attention 50 years ago.

HIGH STANDARDS SET

Purity in medical advertising was a new development when The JOURNAL was first published. The annual report for 1908 states that The JOURNAL was one of only a few in which high standards for advertising prevailed, and it was the only journal at that time which had been inaugurated with such standards at the start. Many thousands of dollars worth of advertising contracts were refused in complying with the standards set up by the Council, standards which today are taken for granted.

However, despite these material changes, the ideals and ethics of medical practice, and the fundamentals of good practice as exemplified in the scientific articles of 1908 are the same today as they were then.

The duty of a doctor to his patients, the advantages and possible errors of diagnostic methods, the anatomical and physiologic bases for study of disease, and the function of the state board of health were the subjects covered in original articles in the initial issue:

The Doctor: His Relation and Duty to the State, David C. Peyton, Jeffersonville, President of the Association.

Some of the Advantages and Possible Errors of the Radiograph in Renal, Ureteral and Bladder Surgery, W. N. Wishard, Indianapolis.

Anatomical Basis for Reflex Movements, Burton Dorr Myers, Bloomington.

Spina Bifida, Miles F. Porter, Fort Wayne.

The Work of the Indiana State Board of Health, J. N. Hurty, Indianapolis.

The leading article for January, 1908, by Dr.

David C. Peyton, is reproduced in the present issue to illustrate the heritage of ideals with which the medical profession is blessed. Ethics and ideals are the one great constant of medicine, originating in ancient times, and prevailing throughout the centuries and into the future, changeless in an ever changing world.

ORIGINAL ARTICLES

THE DOCTOR.

HIS RELATION AND DUTY TO THE STATE.

DAVID C. PEYTON, M.D.
President of the Indiana State Medical Association
JEFFERSONVILLE, IND.

The word doctor means a teacher. A doctor of medicine means a teacher of medicine; a doctor of divinity, a teacher of divinity; and a doctor of law, a teacher of law. The writer is inclined to a broader construction or definition, for he believes that a doctor of medicine is not only a teacher of medicine, but is, or should be, a teacher and a leader in the broadest sense. The public looks upon the doctor as a storehouse of general information, which he generally is if he reaches and maintains that pinnacle of true merit and confidence that the public is inclined to give him. It is unfortunately true that a few members of our great profession have established in their own minds a lower ideal as their standard, which, of course, detracts from their real worth and reflects discredit upon the higher ambitions and ideals of the profession. No truth is more generally accepted than the fact that doctors have been teachers and architects of public opinion from the earliest history of medicine. A reverence for the true, the beautiful and the real has characterized physicians in all times. For a long time progressive medicine was handicapped by failure of students of science to emancipate themselves from the prejudices and superstitions of the times. In this connection I might quote a paragraph from an article by King in "The Nineteenth Century" for 1893: "The difficulties under which medical science labors may be estimated from the fact that dissection was forbidden by the clergy of the Middle Ages on the grounds that it was impious to mutilate a form made in the image of God. We do not find this pious objection interfering with such mutilation when affected by means of the rack and the wheel and such other clerical, rather than medical, instruments."

Higher medical education, with its ever increasing requirements for entering upon the study of medicine, is exactly the right thought and the right spirit, and should be encouraged and maintained by the members of the profession who are willing to stand by the principle of higher ideals. The writer would advocate the enactment of a law requiring all doctors to stand state board examinations once in every five years. This would serve as an incentive to doctors to establish and continue a well directed course of study and to further establish their rights and claims to the position of teacher. It would also serve to impress doctors with the importance of taking advantage of the postgraduate course, as planned by the American Medical Association, which deserves the commendation of every member of the profession. Such a law would result in the general uplifting of the scientific standard of the profession by causing those members who are capable and willing to reach the higher standard, and by eliminating those who are unwilling or incapable of maintaining a progressive position.

Such exacting regulations might be questioned, except for the fact that ours is the one profession whose duty it is to deal not only with human confidences but with human life itself. I speak of the profession of medicine advisedly, because ours is truly the only profession. The law and the ministry are not professions in the strict sense of the word, as is readily understood. They practically have no standard of legalized requirements, either for entering upon their study or for maintaining a higher standard after once admitted.

Another thing indicative of the former establishment of the principle of higher medical education and higher ideals is the establishment by many of the state medical associations of official journals, and it gives the writer pleasure to be at the christening of the first issue of THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION and to bid those upon whose shoulders the most of the burden for its success must of necessity rest, a hearty Godspeed in their mission of a general scientific uplifting.

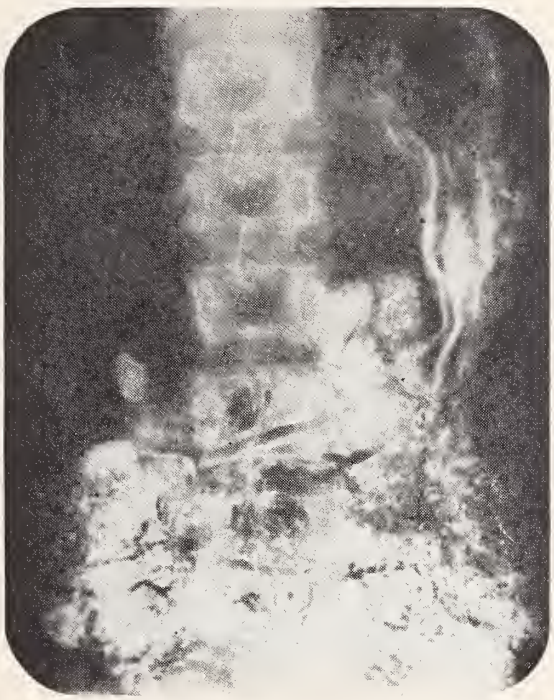
The writer is an advocate of the idea that the doctor should take a most serious view of the business or financial side of the practice of medicine. While it is true that our profession is founded upon altruistic principles, it is also true that ultra-altruism is not sufficient to meet the exacting demands made upon doctors by the members of the various commercial interests who have been schooled in the modern rigid ideas of commercial principles. The doctor's success or failure depends upon his ability to establish and maintain a respectful supremacy, and in order to do this he must not only merit the confidence of the people in a professional way, but he must so conduct the business side of his profession as to give him recognition in the commercial circles. No man of our profession of ten years' experience would, I think, were he about to begin life over again, adopt medicine and surgery as his life work, were he actuated simply by the desire to

(Please turn to Page 62)

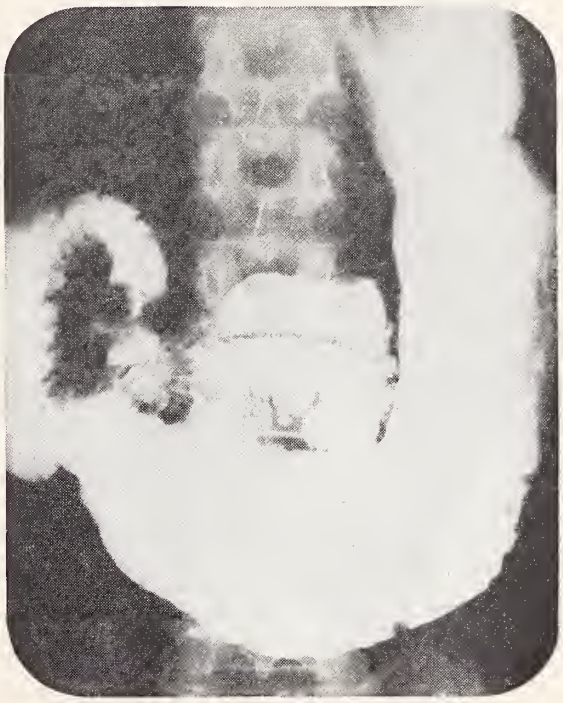
DIAGNOSTIC AID

Reduced Hypermotility with Pro-Banthīne®

Improves Visualization



*Posterior-anterior film: definite hyperperistalsis with poor duodenal visualization.**



Posterior-anterior film after 15 mg. of Pro-Banthīne intramuscularly: chronic duodenal ulceration clearly disclosed.

The same anticholinergic action which has made Pro-Banthīne (brand of propantheline bromide) the outstanding therapeutic agent in peptic ulcer has also proved valuable in diagnosis.

By controlling the hypermotility, Pro-Banthīne may permit delineation of a lesion otherwise not clearly visualized.

The technic is simple: If the first set of films shows hypermotility but no filling defect is demonstrable, reexamination is done a few minutes after intramuscular injection of 15 mg. or a half hour after oral administration of 30 mg. of Pro-Banthīne.

This procedure has the additional advantage of demonstrating the patient's response to a given dosage of the drug.

G. D. Searle & Co., Chicago 80, Illinois, Research in the Service of Medicine.

*Roentgenograms courtesy of I. Richard Schwartz, M.D., Kings County Gastrointestinal Clinic, Brooklyn, N.Y.

SEARLE

acquire wealth. People when in sickness and distress fly instinctively to the medical man for comfort, protection and relief, and as promptly forget all about the necessity for remuneration when the danger is past and a condition of health restored. In this connection the following quotation seems apropos:

> God and the doctor we alike adore
> When sickness threatens us, but not before;
> The danger past, both are alike requited,
> God is forgotten, and the doctor slighted.

Again, the doctor owes a certain duty to his state, and in order that he may be able to measure up to the standard of requirement he must of necessity combine three principles, as his duties are threefold, being scientific, commercial and political.

The members of the legal fraternity have assumed a position of legislative guidance, and they have assigned themselves the function of complete direction of affairs of state in this respect. By reason of this assumption and their concerted effort they have, and do now, control the making of our laws, and in every other way have piloted the ship of state. There is no good reason why this should be, either from the standard of intellectuality or equity, and the doctor owes it not alone to himself, but as a public duty and one of the fundamental duties to which he should school himself, to not only take a position, but a leading one in the commercial and political economy of his state. The great underlying principle of our social and political preferment is public health, and who of all members of society is so competent to counsel wise laws, regulating and maintaining these principles, as the doctor? This should not be looked upon from a selfish standpoint with a view of personal or individual opportunity, but should be accepted by the medical profession as a great principle of duty, and there is no reason why with the present splendid organization in the State of Indiana the physicians of the state should not rise to the full measure of their duty.

A Laboratory Incident

JANE M. KETCHAM, M.D.

Indianapolis

EARLY IN MY PRACTICE the Abderhalden test for pregnancy appeared. It seemed to me that I, not being a laboratory worker, could do something with this test. I was the Juvenile Court doctor and house doctor for what was then known as the Door of Hope and now known as the Sue Emma Coleman Home. At least I would have material with which to work.

With some guidance, after two years I presented the matter to the Medical Society here. There were three essentials to the test: Blood to be tested, known negative blood, and known positive blood. I called on all my friends for negative blood, and the Juvenile Court and the Home supplied the other two.

After two years of this activity and almost daily venesections on myself, I landed at Saranac Lake. After a brief spell of convalescence, Dr. Trudeau asked me to set up this test. I was glad to do it. We found blood to be tested, and positive blood, but when it came to negative blood for a control, no one in the village at Saranac was willing to give up any. Eventually, Salisbury, the janitor of the laboratory, was pressed into service. The following morning he refused to eat his breakfast. Such a thing had never happened before. His wife asked him if he were sick. "No," he said. "I am not sick." After a great deal of pressing, he explained that he couldn't eat his breakfast because he was having a test for pregnancy. So then she *knew* he was crazy.

The Abderhalden test for pregnancy has long since gone out of use and has been superseded by the A-Z and the frog test, and others, but it served a useful purpose to me.

The First Fifty Years Are the Hardest

GOETHE LINK, M.D.

Indianapolis

WHEN DR. RAMSEY told me that I had an article in the first volume of The JOURNAL of the Indiana State Medical Association, I could hardly believe it. Then I recalled how good the editors of the two Indianapolis Medical Journals which preceded our State Journal were to me. Dr. S. E. Earp and Dr. A. W. Brayton encouraged me to write and, though many of my early efforts must have been of doubtful value, they never once failed to publish my work. With the practice and help given me by these editors I was ready with something for our State Journal and the editor accepted it.

Sometimes I think that our young men in the profession do not realize what a fine thing it is to have a State Journal of our own in which they may learn to write by writing for publication. One can only learn to write by hard work, by writing and rewriting. To have a high class publication like our Journal of the Indiana State Medical Association as an outlet for the product of your labor is a wonderful opportunity not to be lightly regarded.

It hardly seems possible that my brief span of surgery should almost cover the entire period of modern surgery. I have seen the development of asepsis and the introduction of rubber gloves. When I began there were surgeons still active who not only did not practice asepsis but they did not even believe in it. I recall one who would go through all the motions of scrubbing, and gowned and scrubbed would forget, reach around to his hip pocket, take out his handkerchief and blow his nose. Realizing his mistake he would then slyly glance around to see if his break in technic had been noticed. We liked him and we pretended not to see his *faux pas*. At that time there was no goiter surgery in this country. I saw one attempt to remove a goiter while I was a student, it ended with death on the operating table in a great flurry of hemorrhage and asphyxia.

Graves disease was cared for by the neurologist. Large nodular goiters were treated with amber beads or were charmed away with a dried snake skin. I was director of the anatomical laboratory and since the head and neck was the despised portion I could not get a demonstrator for that part and for several seasons was obliged to teach the anatomy of the head and neck myself. This work directly led me into the slowly developing field of thyroid surgery. There were no anti-thyroid drugs, the use of iodine had not yet been given to us by Plummer and it was necessary to do ligations of the thyroid arteries on more than 50% of goiter cases in order to prepare them for safe thyroidectomy. Thyroid surgery in those days was tough sledding. On one patient I did six operations including ligations, lobectomies and recurrences. I finally got her through alive and she later raised a large family.

Much progress has been made since then. My first thyroidectomy done August 1911 died. When I talked to Charles Mayo about my misfortune he kindly consoled me by telling me that of his first 16 thyroidectomies he lost 4. He then emphasized the need for more careful preoperative preparation and ligations, a lesson of great value to me. As evidence of progress I have now an unbroken series of 1,760 thyroidectomies without a death.

Much of this improvement is due to better operating room conditions and better nurse help. At one time all cases were drained and all were more or less infected. This gave rise to severe post-operative reaction, frequently with transient

tetany from inflammatory swelling of the stumps. Convalescense included several weeks of dressing draining wounds. The waiting room was full of patients come to be dressed and the waste basket was full of foul smelling dressings at the end of the day. Now one or two inspections of a healed wound suffices.

Modern surgery has become a matter of more coordinated team work, all parts of which must come up to a level to give the results we get. This consists of diagnosis, timely action and preparation by the general practitioner, further preparation by the cardiologist as is often needed and careful operating room technic by the nursing staff, all a necessary foundation enabling the surgeon to achieve success with his carefully directed efforts.

Let me repeat, that to prepare an article for publication about a particular field of your choice is a great stimulus toward good work.

HE WORKS FURIOUSLY

The puritan teaching of abstemiousness and hard work is far from dead. In fact, in some ways other-directed values reinforce it. Take for example the passing of the gilded age. The rich industrialist or merchant no longer displays his opulence by building magnificent mansions on the hill overlooking his employees below. He no longer flaunts his wealth with diamond stickpins and beaver top hats. His wife is no longer Veblen's "pack horse" loaded with the evidence of his success. The age of conspicuous expenditure is gone, and not simply because of the income tax or the fear of arousing left-wing ire. Only the occasional movie personality tries to recapture it. Today the industrial chieftain truly and conscientiously practices inconspicuousness in dress, home, and manner. He works hard at the office every day (and sometimes night) the year around. It is a matter of pride with him that he started out selling newspapers on the corner (although I am sure some make the claim who did not), that he has not had a vacation in 19 years, and that he has not been home in time for dinner in three weeks. When he takes a vacation, he spends it in the exhausting exercise of chasing a golf ball over 10 acres in the brutal sun. And when he is home on an occasional evening, does he lie around the house and relax? No indeed; he works furiously in his basement workshop. These behavior patterns have been elevated to the level of other-directed status symbols. You live relatively modestly for your means, work hard, and die with your boots on. The current corporate practice of requiring regular medical check-ups for executives, the many articles in business publications on this subject, and the incessant talk about teaching executives how to taper off and enjoy retirement are indicative of how much single-minded hard work still dominates in business circles. How to enjoy leisure remains a deep mystery.

—From "The Changing Character of Capitalism," by Theodore Levitt, in *Harvard Business Review,* July-August, 1956

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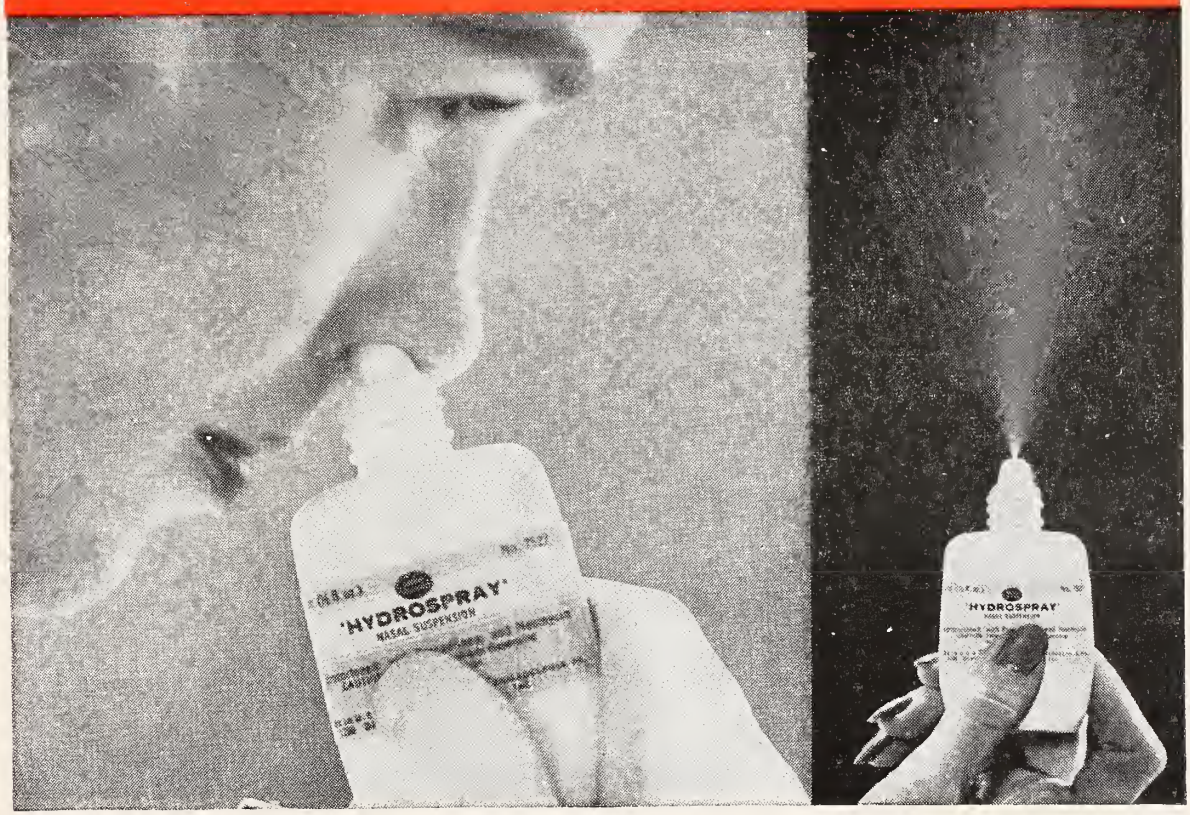

Topically applied hydrocortisone[1] in therapeutic concentrations has been shown to afford a significant degree of subjective and objective improvement in a high percentage of patients suffering from various types of rhinitis. HYDROSPRAY provides HYDROCORTONE in a concentration of 0.1% plus a safe but potent decongestant, PROPADRINE, and a wide-spectrum antibiotic, Neomycin, with low sensitization potential. This combination provides a three-fold attack on the physiologic and pathologic manifestations of nasal allergies which results in a degree of relief that is often greater and achieved faster than when any one of these agents is employed alone.
INDICATIONS: Acute and chronic rhinitis, vasomotor rhinitis, perennial rhinitis and polyposis.

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REFERENCE: 1. Silcox, L. E., *A.M.A. Arch. Otolaryng.* **60**:431, Oct. 1954.

Strong Plea for Individual Freedoms Made by A.M.A.'s President Murray

"We have been caught in the throes of a social revolution which demanded something for nothing. Changes have been taking place all around us, and medicine has not escaped unscathed", Hoosier-born Dwight A. Murray told the opening session of the House of Delegates in Seattle.

ALMOST SIX MONTHS have elapsed since we last met to deliberate and act on medical affairs. The time has passed quickly, but not quietly.

The rumble of war and revolution has resounded in our ears. The din from political battle has been deafening.

All of us . . . sooner or later . . . learn that today's events do not just swirl around us, but involve each of us. As doctors we cannot get away from them by claiming that our only interest is in the sick, and that we cannot be bothered by political, social and economic problems. These matters demand attention from the doctors as well as the lawyer, the businessman, the newspaper editor, the labor leader and the worker.

If we are concerned about what happens on the international, national and local fronts—and we should be—then certainly we cannot afford to be disinterested in what happens in our own area of health and medical affairs. Yet there is apathy in our ranks.

REPLACE APATHY WITH ACTIVE, UNITED PROFESSION

Today there is a greater need for a united, forceful and informed profession than ever before. *We have been caught in the throes of a social revolution which demanded something for nothing. Changes have been taking place all around us, and medicine has not escaped unscathed.*

For example, in a few days Public Law 569, the bill providing medical care for military dependents, becomes effective throughout the land. Contracts already have been signed with the government by the majority of our state societies. No longer can any doctor claim that this law does not affect him. No longer can he say that government laws really are not changing the practice of medicine.

Public Law 880, better known to all of us as H.R. 7225, is another case in point. Medicine now is facing the problem of protecting the taxpaying public from abuses and of cooperating with the government to carry out the provisions of the law. The law is now on the books, and we must provide the leadership necessary to make it work as well as possible.

It was encouraging to hear Ezra Taft Benson, Secretary of Agriculture, say last week before the American Association of Land Grant Colleges and Universities:

"Sooner or later, the accumulation of power in a central government leads to a loss of freedom. . . . Raids on the federal treasury can be all too readily accomplished by an organized few over the feeble protests of an apathetic majority. With more and more activity centered in the federal government, the relationship between the cost and the benefits of government programs becomes obscure. What follows is the voting of public money without having to accept direct local responsibility for higher taxes. . . .

"If the present shift of power from state to federal authority which started 25 years ago is allowed to continue, the states may be left hollow shells."

It was encouraging to hear such comments from a member of the President's Cabinet. I only wish that all members of the official family,

little

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and more important, every member of the United States Congress, felt the same way.

The expression of this philosophy, with which medicine so heartily agrees, sounds good, but putting it into practice is the thing we are really interested in.

Today the medical profession along with business and industry is caught between those who desire to promote sound government programs and those who desire even more intensely to perpetuate party power. Unfortunately, in recent years a benevolent federal government appears more attractive to the voting public than the preservation of individual freedoms. Medicine must do its utmost to reverse this trend.

MEDICAL FREEDOM ESSENTIAL

In my travels around the country as your representative the last 18 months, I have seen little dissension or rancor within our ranks. However, I must report that I have seen too much complacency over governmental encroachment into medical affairs. And I am deadly serious when I say to you that apathy by the few, or by the many, can be detrimental to all.

No nation can merely reap the benefits of freedom; it also must sow seeds of freedom.

In medicine the situation is the same. If an apathetic medical profession takes its freedom for granted, it will be the beginning of the end. A strong, free profession must work for freedom so that it may live in freedom. And history tells us that once medicine loses its freedom, other fields of private endeavor are immediately in danger.

I do not wish to paint a dark or distorted picture of medicine's free status and its stature in America today. But I do believe words of caution and an appeal for vigilance are in order.

The road of apathy and disunity can only lead to disorder and perhaps disintegration, and we must sound a warning to all our colleagues who don't care, or who are pulling in the opposite direction. The road of alertness, action and unity is the proper road for all of us to be traveling together.

If I had just one wish for the coming year, it would be to command the time and talents of the 160,000 physicians in the American Medical Association. I would set us all to the task of emphasizing and reemphasizing the absolute necessity of patient and professional freedom.

PATIENT'S RIGHT TO CHOOSE HIS DOCTOR

I believe it is one of our prime responsibilities to prove to our patients that their right to choose their doctor is a most important one.

Free choice brings a bond of confidence between doctor and patient which no compulsory medical system can create. It means that the patient knows the physician will be interested in him as a person, not as just a serial number or the 2:45 appendicitis case.

For the doctor free choice means that the patient has selected him for his abilities, training, sincerity and personality. When a patient comes into my office, I know he has made a choice. And from that moment there begins a physician-patient relationship of the highest order. To me the patient is someone special, and I in turn hope that I am someone special to him.

Once the patient has made his choice, the physician automatically assumes an unqualified responsibility to the patient. No system of medical care that uses a third party to bring doctor and patient together can match our kind of cooperative performance for the treatment of illness, the cure of disease and the betterment of the patient's health.

Freedom to select a doctor is part of everyone's great freedom to choose—to choose what he wears and eats; where he works and worships, and how he votes. Take away any part of this freedom and great damage is done to our democratic system.

FREE CONDUCT IN MEDICAL TREATMENT

Another freedom closely tied to freedom of choice is freedom in the conduct of medical treatment.

At the recent meeting of the World Medical Association in Havana, Cuba, Dr. Rolf Schloegell of Germany made a stirring defense of free conduct of medical treatment. He told us that the medical profession believes the attending physician alone is competent to decide what

Doctor, would it be helpful to you in your practice to know that there is a food available at reasonable prices in the stores the year round having these attributes:

1. High public acceptance as to flavor and palatability—billions eaten annually.

2. One of the best of the "protective" foods with a well-rounded supply of vitamins and minerals.

3. Low sodium—very little fat—no cholesterol.

4. Sealed by nature in a dust-proof package.

5. One of the first solid foods fed babies.

6. Can be easily digested by old folks as well as infants.

7. Can be readily eaten out of hand, in milk shakes, on cereals, or in salads.

8. Can be baked, broiled or fried.

9. Can be used as an ingredient product in breads, pies, cakes and desserts.

10. Useful in bland and low-residue diets.

11. Mildly laxative.

12. May be used in the management of both diarrhea and constipation.

13. Can be used in reducing diets.

14. Can be used in high-calorie diets.

15. Useful in the dietary management of celiac disease.

16. Useful in the dietary management of idiopathic non-tropical sprue.

17. Useful in the management of diabetic diets.

18. Valuable in many allergy diets.

19. Belongs among foods useful in certain acute intestinal infections.

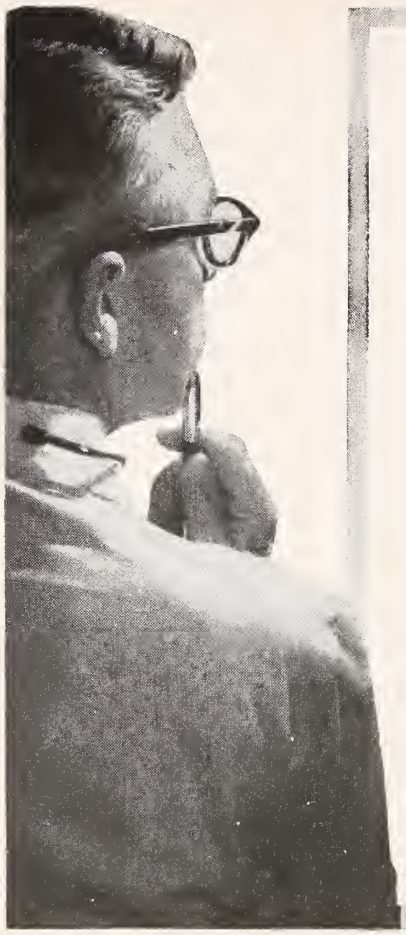
20. A protein sparer.

21. Favorably influences mineral balance.

22. Useful in the management of ulcer diets.

23. One of the easiest foods to eat or prepare.

FOR THE NAME OF THIS FOOD, PLEASE TURN THE PAGE



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2. Additional information in connection with any of them...
3. The composition of the banana . . .
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Strong Plea for Individual Freedoms (Continued)

measures he deems necessary and will apply in order to bring about the desired improvement. He warned too of the danger of excessive restriction on the freedom of the patient and the attending doctor.

Yet the trend toward extending social security in the medical care field has been steady and has accelerated since the end of World War II.

The dangers of shifting responsibilities for medical care from the patient and doctor to the government are obvious. The caliber of medical care cannot be as high when both patient and doctor are dependent upon government. Initiative succumbs to dictation, and self-reliance is replaced by the crutch of government.

We do not deny that there is an area of legitimate concern by the government for the health and welfare of the people. But each year government seems to extend that area. We get some idea of this expansion from the new federal medical budget.

This year, according to our Washington Office, the average family will be paying $54.61 for the U. S. Government's health and medical activities. And the total expenditures this year amount to 2½ billion dollars—290 millions more than last year. Even in an overall federal budget of 61 billion dollars, the total health cost of 2½ billions is not insignificant. It is a billion dollars more than the cost of running the Commerce Department, half a billion more than the Agricultural Department and six times more than the Interior Department's budget.

"BIG BROTHER" COMPLEX

Many expenditures obviously are necessary to keep up our unsurpassed public health standards, and research may pay rich dividends in scientific discoveries. But there is no doubt that much money is being spent on medical activities that should not involve government participation.

The trend is to spend more and more government money on health and medical matters because it is good politics. Apparently many Americans still want to see government in the

(Please turn to Page 72)

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the ONLY broad spectrum antibiotic preparation with added protection against monilial superinfection

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role of a big brother, dishing out so-called gifts and bargains under the guise of benevolent economic planning.

DRIFTING AND DREAMING

I believe it is our duty, as it is everyone else's, to combat the attitude of "what's in it for me?" and to promote the long-honored creed of "what's best for all Americans and our free society." I think that a nation can drift into state medicine inch by inch just as surely as if the scheme were foisted upon a people overnight. The "drift" method may take longer but the result will be the same.

So it is time all of us sounded the alarm against soft and superficial security and against the invasion of personal responsibility. It is time we stood up together for militant freedom and for full rights and responsibilities of the individual.

BELGIAN DOCTORS TURN BACK GOVERNMENT

There is no better example of what a unified medical profession can do than in the story of the recent fight of the Belgian doctors against the government's proposals for a state service of medicine.

Without consulting the medical profession the Belgian government proceeded to draft rules and regulations of health to be incorporated in the nation's social security legislation. Under the proposals doctors were to sign an agreement to abide by the present rules and any later regulations. For the patient there would be the usual red tape in getting medical care.

When the Belgian doctors learned of the scheme, they met in conference with the government. They told the government what they wanted and what they would not accept. The government agreed.

For several months everything was quiet. Then the Belgian doctors suddenly read about the new health bill that the government was sending to Parliament. It was quite contrary to the earlier agreement worked out by the profession and the government. But the bill was passed quickly.

The Belgian medical profession protested and

(Please turn to Page 74)

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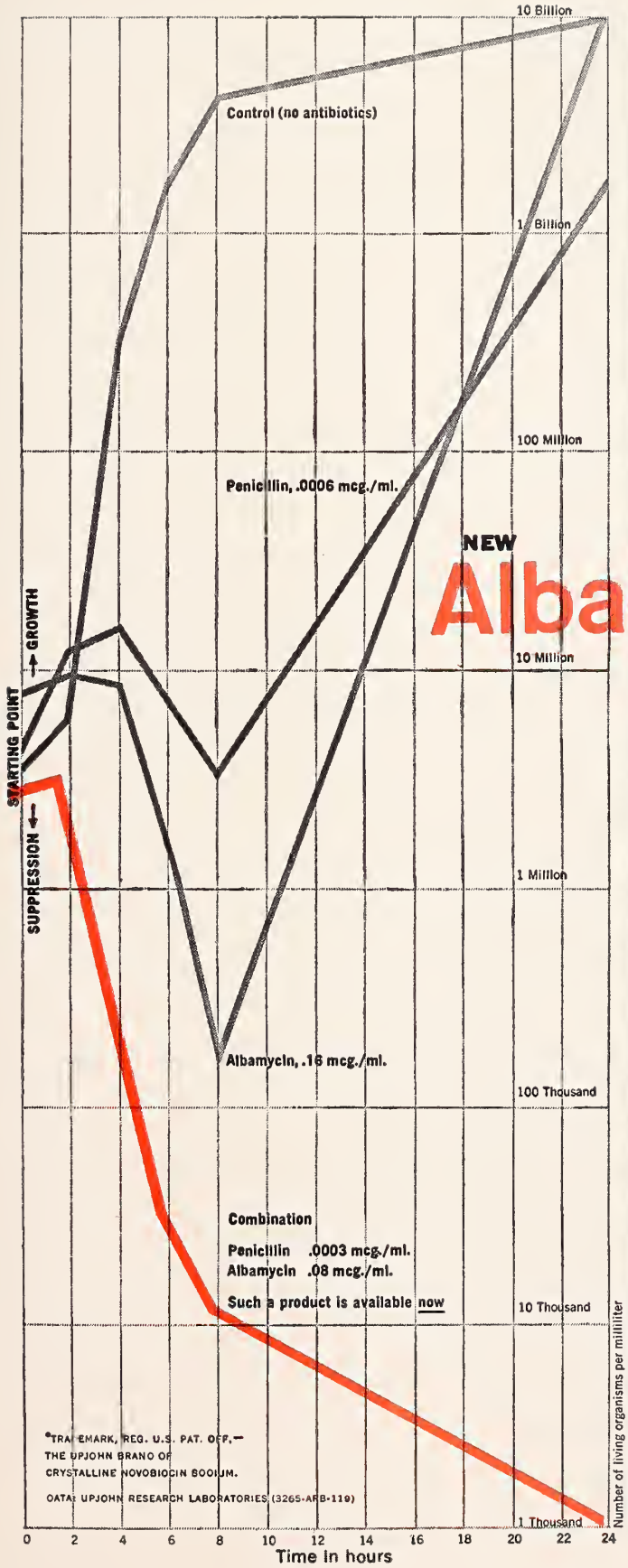

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DATA: UPJOHN RESEARCH LABORATORIES (3265-ARB-119)

average dosage only t.i.d.

antibiotic synergism

The three gray lines of this graph show the growth rate of a penicillin-sensitive strain of Staphylococcus (Micrococcus pyogenes, var. aureus) under 3 conditions:

1. In the absence of antibiotics
2. In the presence of subinhibitory concentration of penicillin
3. In the presence of subinhibitory concentration of Albamycin*

Even **half** these subinhibitory concentrations of penicillin and Albamycin, **when combined,** (black line) produce a dramatic **bactericidal** effect.

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Alba-Penicillin*

(Albamycin plus penicillin)

Compare it with the antibiotic you are currently using:

Range of effectiveness: Alba-Penicillin is effective against the organisms that cause the overwhelming majority of bacterial infections (Staphylococci, Streptococci, Pneumococci, Proteus).

Risk of resistance: Because in vitro tests show this combination is synergistic against even Staphylococci **already** resistant to all other antibiotics, the risk of resistance is minimized.

Risk of enterocolitis: Because it has little or no effect on the predominant Gram-negative intestinal bacteria, and is highly effective against Staphylococci, there is virtually no danger of enterocolitis due to alteration in intestinal flora, or of other side effects such as perianal pruritus.

Convenience: Alba-Penicillin is oral therapy, and the average adult dosage is only **1 to 2 capsules t.i.d.,** which eliminates middle-of-the-night medication.

It is available in bottles of 16 capsules. Each capsule contains 250 mg. Albamycin (as novobiocin sodium, crystalline) and 250,000 units penicillin G potassium.

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Erythromycin in Treating Pneumonia

A 27-year-old man, a chronic alcoholic, was admitted with a history of an alcoholic spree followed by a cough, greenish sputum and chills and fever.

Physical examination showed a temperature of 104 F. and indicated pneumonia in the right lower lobe. This was confirmed by X-ray. The sputum revealed gram-positive diplococci and blood culture subsequently grew Type VII pneumococci.

The patient was treated with erythromycin, 300 mg. every six hours per os. His temperature dropped to normal by 48 hours and X-ray of the chest revealed considerable clearing by the fourth hospital day. After 10 days hospitalization, the patient was fit for discharge.[1]

First Antibiotics Symposium, we reported the successful treatment with thromycin of *H. influenzae* pneumonia and bacteremia. A second patient with *H. influenzae* pneumonia and bacteremia had a clinical course almost identical to the one previously reported, with cure obtained by treatment with 500 mg. of erythromycin per os every four hours for 14 days.

Of these 132 patients with bacterial pneumonia, 127 (96%) had a good clinical result. One patient with lobar pneumonia had a good initial
delayed

"Highly Effective in Pneumonia"

In one investigation, 75 adult patients with bacterial pneumonia were treated with erythromycin. In his summary, the clinician reported: "It is concluded that erythromycin is highly effective in the treatment of pneumonia due to gram-positive bacteria."[2]

This, of course, is only one of many reports showing the effectiveness of ERYTHROCIN against coccic infections. You'll get the same good results (nearly 100% in common, bacterial respiratory infections) when you prescribe ERYTHROCIN. Abbott

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STEARATE

"No Serious Side Effects Occurred"

After a study of 171 patients treated with erythromycin, the investigator wrote: "No serious side effects occurred with prolonged therapy or with doses up to 8 Gm. per day in the severe infections."[1]

Actually, ERYTHROCIN stands on a remarkable record of safety. After four years, there's not a single report of a severe or fatal reaction attributable to erythromycin. In addition, you'll find allergic manifestations rarely occur. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), in bottles of 25 and 100. Abbott

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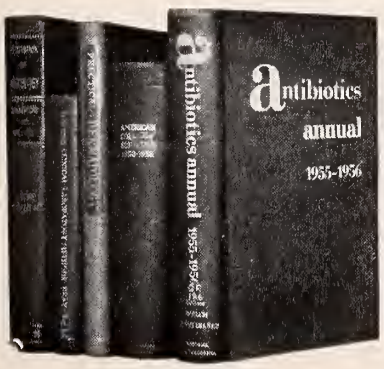

1. Romansky, M.J., et al., Antibiotics Annual 1955-1956, p. 48,
2. Waddington, W. S., Maple, F. C., and Kirby, W. M. M., A.M.A. Archives of Internal Medicine, 1954, p. 556.

70106-1

the improvement of the health and welfare of the individual and the community.'

"In view of the above your reference committee believes that the proposed Principles of Medical Ethics should be referred back to the Council on Constitution and By-Laws for further study and consideration of the above stated principles.

"In the short space of time at our disposal and in view of the importance of the subject, your reference committee did not deem it wise to attempt to properly phrase these concepts.

"We would also recommend that if possible this study be completed at least six weeks prior to the June session and that the new version be published in The JOURNAL in order that all interested physicians might have an opportunity to comment thereon."

VETERANS' MEDICAL CARE

The House revised A.M.A. policy on veterans' medical care by endorsing in principle the following paragraph suggested by the Council on Medical Service:

"With respect to the provision of medical care and hospitalization benefits for veterans in Veterans Administration and other federal hospitals that new legislation be enacted limiting such care to veterans with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated."

This action eliminates the temporary exceptions which were made in the June, 1953, policy regarding wartime veterans who are unable to defray the expenses of necessary hospitalization for non-service-connected cases of tuberculosis or psychiatric or neurological disorders. In making the policy change, the House approved this supplementary statement:

"We recognize the laws and administrative extensions of the law that are now in operation. We feel that under the circumstances it will be to the best interests of the public in general, and veterans in particular, if medical societies,

(Please turn to Page 85)

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county and state as well as national, develop committees to assist in guaranteeing VA hospital admission to service-connected cases. While the present law exists, we should help assure that veterans whose illness constitutes economic disaster will not be displaced by those suffering short-term remedial ills which, at the worst, constitute financial inconvenience."

In another action concerning veterans, the House passed two resolutions condemning as unlawful the practice of Veterans Administraiton hospitals which admit patients who are covered by workman's compensation insurance or by private health insurance and which render bills for the cost of their care. Both resolutions requested the A.M.A. to take action to bring about a discontinuance of such practices by VA hospitals, and one of them instructed the Association Secretary to obtain from each state testimony or records of each known case that violates VA Reg. 6047-D1.

RADIOACTIVE ISOTOPES

The House rescinded the June, 1951, action, which limited the hospital use of radium and radioactive isotopes to board-certified radiologists, by approving a new policy statement which says:

"(1) In any hospital in which a patient is to receive radium or the products of radium or artificially produced isotopes, there should be a duly appointed Committee on Radium and Artificially Produced Radioisotopes of the hospital professional staff. This committee should include, but not necessarily be limited to, the following qualified physicians: a radiologist, a surgeon, an internist, a gynecologist, a urologist and a pathologist. This committee should have available such competent consultation of other physicians and scientific personnel as may be required by it. Where this is not practicable, the hospital staff should consult the nearest Committee on Radium and Artificially Produced Radioisotopes.

"(2) In any hospital, the use of radium or its products and artificially produced radioactive isotopes for diagnostic or therapeutic purposes shall be restricted to qualified physicians so judged by the Committee on Radium and Arti-

Clinical Reviews

MAYO CLINIC
AND
MAYO FOUNDATION
ROCHESTER, MINNESOTA
APRIL 1, 2 AND 3, 1957

Staff members of the Mayo Clinic and the Mayo Foundation for Medical Education and Research will present again this year a three-day program of lectures, discussions and demonstrations on problems of current interest in general medicine and surgery.

Up to twenty-one hours of Category I credit may be obtained by American Academy of General Practice members who attend.

There are no fees for this program.

The number of physicians who can be accommodated is necessarily limited. Those wishing to attend should communicate with Mr. R. C. Roesler, Mayo Clinic, Rochester, Minnesota.

ficially Produced Radioisotopes of the professional staff to be adequately trained and competent in their particular use.

"(3) It is recommended that procurement, storage, dosimetry control and inventory of all radioactive isotopes for the use of the hospital staff and radiological safety control be centralized, and, where administratively possible, centralization be located in the Department of Radiology.

"(4) It is recommended that the Board of Trustees assign to the appropriate council or committee the continuous study of the problems of radiological safety control in the use of radium and its products and artificially produced radioactive isotopes for diagnostic or therapeutic purposes."

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GRADUATE SCHOOL OF MEDICINE

INTENSIVE POSTGRADUATE COURSES

STARTING DATES—WINTER, 1957

SURGERY—
Surgical Technic, Two Weeks, January 28, February 11
Surgery of Colon & Rectum, One Week, March 4
General Surgery, One Week, February 11
Surgical Anatomy & Clinical Surgery, Two Weeks, March 11
Surgical Pathology, 2 or 4 Weeks, by appointment
Fractures & Traumatic Surgery, Two Weeks, March 11
Gallbladder Surgery, Three Days, April 8

GYNECOLOGY & OBSTETRICS—
Office & Operative Gynecology, Two Weeks, February 11
Vaginal Approach to Pelvic Surgery, One Week, February 4
General and Surgical Obstetrics, Two Weeks, February 25

MEDICINE—
Electrocardiography & Heart Disease, Two-Week Basic Course, March 11
Gastroenterology, Two Weeks, May 13
Gastroscopy, Two Weeks, March 18

RADIOLOGY—
Diagnostic X-Ray, Two Weeks, February 4
Clinical Uses of Radioisotopes, Two Weeks, May 6
Radioactive Iodine, One Week, April 1

UROLOGY—
Two-Week Course, April 1
Gynecology, Ten Days, by appointment

PEDIATRICS—
Two-Week General Course, May 13

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

ADDRESS

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CLINICAL MEETINGS

Rejecting a resolution which recommended discontinuance of the interim sessions, or clinical meetings, the House adopted a reference committee report which said:

"We believe that the interim sessions should be continued because of the public relations value of these meetings to the Association and the educational value to physicians and the general public in the various geographical areas involved.

"It is the suggestion of the reference committee that maximum attention be given to these potential benefits in selecting a city for the interim meeting.

"It is our further recommendation that the Board of Trustees consider the advisability of holding an Interim Meeting of the House of Delegates in Chicago each November or December and an Interim Scientific Session in November or December of each year in different parts of the United States. The reference committee suggests that the views of the Board of Trustees in this regard be reported to the House of Delegates next June."

HOSPITALIZATION FOR ALCOHOLICS

To implement educational approaches to the problem of alcoholism, the House approved a statement submitted through the Board of Trus-

(Please turn to Page 88)

A more complete gall bladder regimen in a single tablet...

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Extracts of Whole Bile (Equal parts Ox and Hog) ..... 210.0 mg.
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Riker LOS ANGELES

tees by the Council on Mental Health and its Committee on Alcoholism. The House also recommended that the statement be brought to the attention of the Council on Medical Education and Hospitals, the Joint Commission on Accreditation of Hospitals and the American Hospital Association. It includes the following:

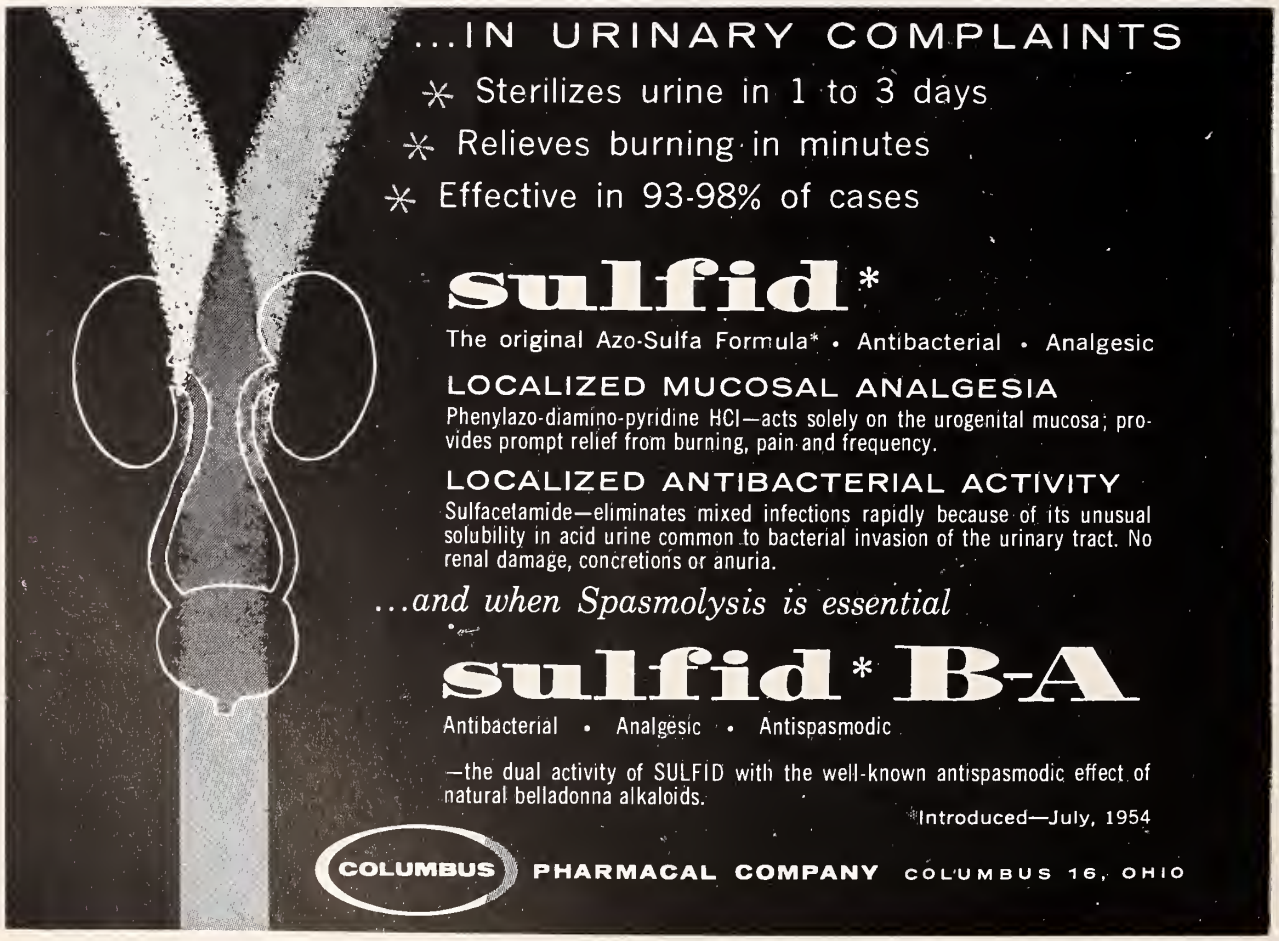
"The Council on Mental Health urges hospital administrators and the staffs of hospitals to look upon alcoholism as a medical problem and to admit patients who are alcoholics to their hospitals for treatment, such admission to be made after due examination, investigation and consideration of the individual patient. Chronic alcoholism should not be considered as an illness which bars admission to a hospital, but rather as qualification for admission when the patient requests such admission and is cooperative, and the attending physician's opinion and that of hospital personnel should be considered. The chronic alcoholic in an acute phase can be, and often is, a medical emergency."

COMMITTEE ON MEDICAL PRACTICES

In approving a progress report of the Committee on Medical Practices, the House amended one of its directives to read as follows in order to remove any legal objections:

"The A.M.A. representatives on the Joint Commission on Accreditation of Hospitals be instructed to stimulate action by that body leading to the warning, provisional accreditation, or removal of accreditation of community or general hospitals which exclude or arbitrarily restrict hospital privileges for generalists as a class regardless of their individual professional competence where such policies adversely affect the quality of patient care rendered. Any action taken should be only after appeal to the Commission by the county medical society concerned."

The House also approved a recommendation by the Committee on Medical Practices that a



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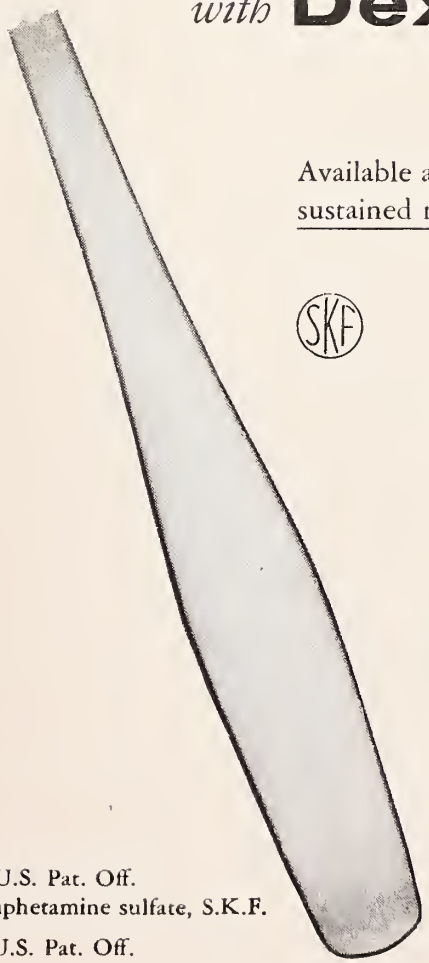

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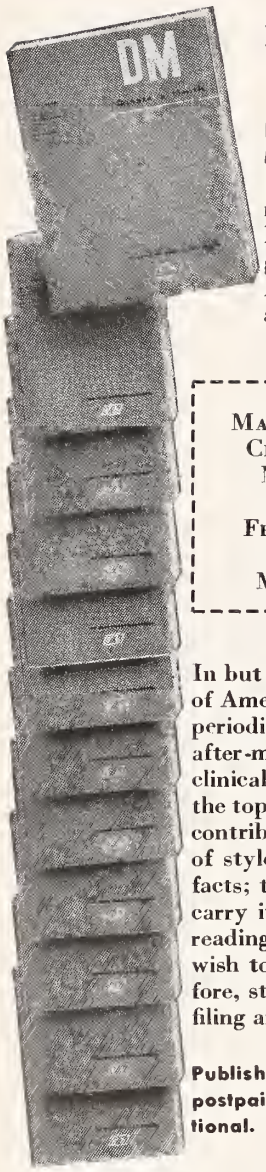

EXAMPLES OF FORTHCOMING MONOGRAPHS: The Purpuras (Harrington), Peripheral Arterial Insufficiency (De Bakey), Electrolyte Disturbances in Congestive Heart Failure (Seldin), Anxiety States (Shands), Headache (Graham), etc., etc.

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2-1-7

Highlight of 10th Clinical Meeting (Continued)

study group be formed to consider the best background preparations for general practice, and it urged that such action be implemented as soon as practicable.

MISCELLANEOUS ACTIONS

Among many other actions on a wide variety of subjects, the House of Delegates also:

Urged the widest possible publication and distribution of Dr. Murray's presidential address at the opening session;

Pledged the full support of the Association's initiative and energy to President Eisenhower's people-to-people program as a means of promoting understanding, peace and progress;

Directed the Board of Trustees to continue its investigation of the practicability of developing a statement of A.M.A. policies and to arrange for the periodic publication of revised versions of such a policy statement;

Commended the objectives of the American Association of Medical Assistants and its sincere desire to work closely with the medical profession in improving medical service and medical public relations;

Noted with pride the good work being done by the 74,348 members of the Woman's Auxiliary, as reported to the House by Mrs. Robert Flanders, President;

Directed the Councils on Pharmacy and Chemistry and on Foods and Nutrition to conduct a joint study of all presently available information concerning the fluoridation of public water supplies and to present a documented report of findings and recommendations at the December, 1957, meeting;

Urged all physicians to participate actively in the formulation of medical policy for prepaid medical care plans which are under physician direction or sponsorship;

Changed the By-laws to extend service membership to reserve officers on extended active duty with the defense forces and the U. S. Public Health Service;

Changed the By-laws relating to transfer of membership so that an active or associate mem-

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ber of the Association who moves his practice to another jurisdiction may continue his A.M.A. membership by applying for membership in the constituent association in his new jurisdiction, subject to a two-year limit on approval of his application;

Changed the By-laws so that the election of officers may take place at any time on the fourth day of the annual session, instead of being restricted to the afternoon of that day;

Passed a resolution calling for the American Medical Association to join with the American Hospital Association and the American Institute of Architects in their proposed study of hospital design and construction;

Approved the principle of a voluntary reduction in the self-assigned quota of interns as printed in the 1956 handbook of the National Intern Matching Program, and

Instructed the Board of Trustees to accentuate cooperation between the American Medical Association and the American Bar Association to the end that a bill of the Jenkins-Keogh type be enacted at the next session of Congress.

OPENING SESSION

At the Tuesday opening session Dr. Murray, on behalf of the American Medical Association, presented a special citation to Ciba Pharmaceutical Products, Inc., for "the service it has performed to the medical profession and to the nation through its weekly television series, 'Medical Horizons'." At the same session the American Medical Association and four of its constituent societies—California, Arizona, Utah and New Jersey—contributed nearly $300,000 to the American Medical Education Foundation for aid to the nation's medical schools. The A.M.A. announced another gift of $125,000, bringing this year's total contribution to $343,000. The amounts presented by the four states were: California, $132,981; New Jersey, $25,000; Utah, $11,870, and Arizona, $3,695.

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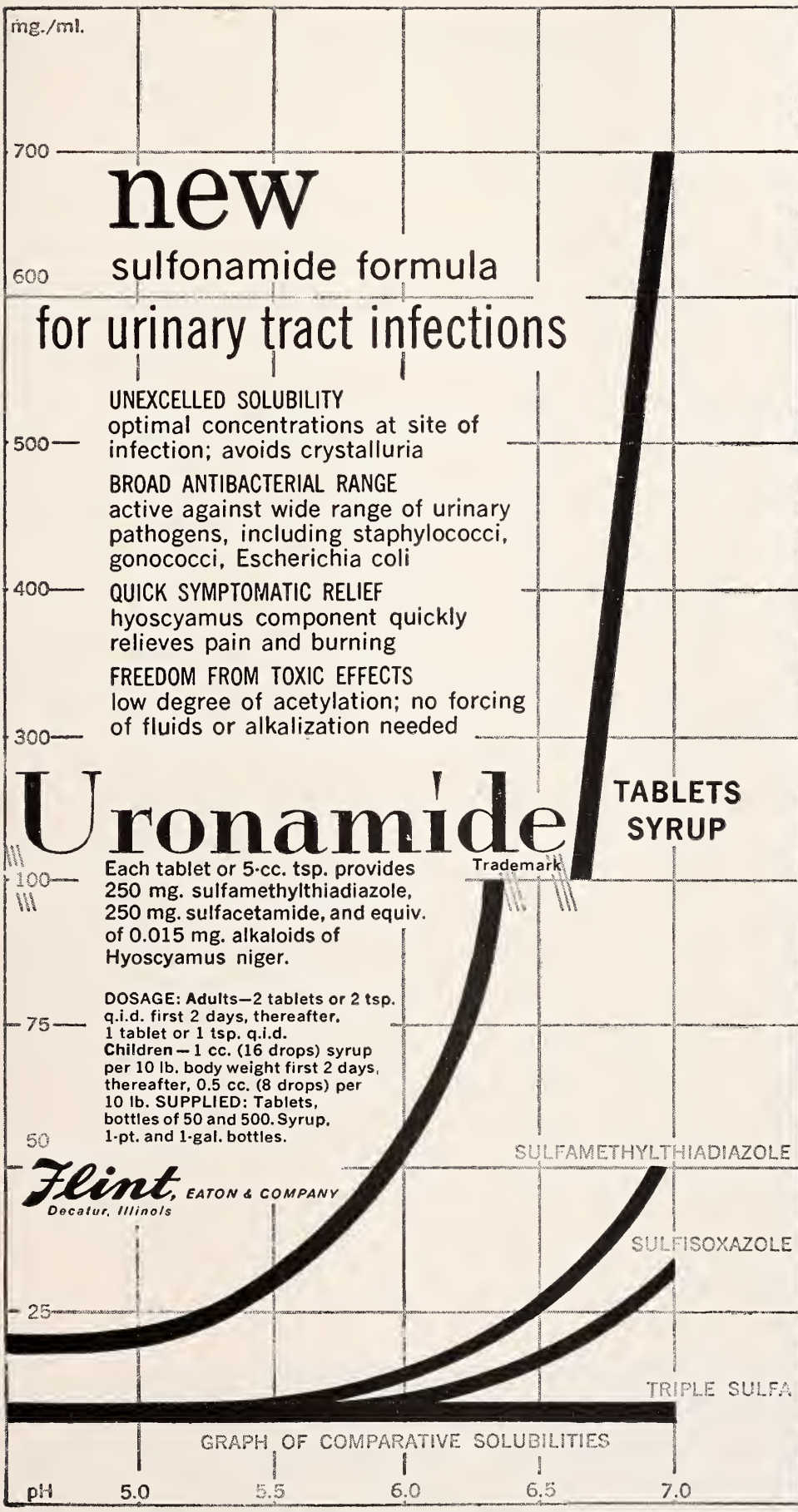

"Sulfamethylthiadiazole . . . effective chemotherapeutic agent in urinary infection...tolerated quite well . . . bacterial spectrum is comparable to that of sulfadimetine and sulfisoxazole."[1]

"[Sulfacetamide] . . . among the least toxic but one of the most effective of the sulfonamides against urinary tract pathogens."[2]

1. Hughes, J., et al.: South. M. J. 47:1082, 1954.
2. Kerley, L., and Headlee, C. P.: J. Am. Pharm. A. (Scient. Ed.) 48:82, 1956

Tests of Oral Antidiabetes Drug Suspended by Pharmaceutical Firm

ELI LILLY AND COMPANY has announced the suspension of the fifteen-month clinical trial of carbutamide, or BZ-55. Carbutamide is a sulfonamide derivative which controls many cases of diabetes when given by mouth.

In a statement, Dr. Kenneth G. Kohlstaedt, director of the clinical research division, said:

"We have communicated this decision to some 2,900 physicians who have been testing carbutamide in more than 10,000 patients. We are grateful to these physicians and to scientists who have participated in what we believe is the most intensive study of a new compound undertaken to date by a pharmaceutical house.

"Our search for a safe oral antidiabetes compound which will relieve certain selected diabetics of the necessity for daily insulin injections is continuing undiminished. In fact we already have other compounds under study which we hope will offer more promise in offsetting the pancreatic defect that underlies diabetes without involving risks unacceptable in wide-scale treatment.

"Discontinuing use of the drug involves no danger to the 10,000 patients who have been controlling their diabetes with it. They may safely return to their former method of control.

"We are not unmindful of the fact that 40,000 patients in Germany have taken carbutamide without any serious side effects being reported by German investigators. Nor are we unmindful of the fact that in our own studies 95 percent of those patients who are able to control their diabetes with carbutamide appear to be able to do so for months without untoward effects. However, among the other 5 percent there have been a few serious side reactions to the drug which are identical to those experienced with other sulfa drugs.

"In view of these findings, and in full consideration that carbutamide is a drug of convenience rather than necessity, Eli Lilly and Company believes it is prudent to suspend the clinical trial pending further investigation. It appears to us that the risks of possible injury and perhaps long-term effects not yet established are greater than any short-term benefits which may seem to be derived from the drug.

"We deeply regret that this compound apparently does not meet the rigid requirements for a drug that must be taken throughout life. At the same time, we are grateful that the study of carbutamide was broad enough and thorough enough to uncover its limitations.

"In the early study of carbutamide in about 700 patients, diabetes experts reported to us that there were almost no serious side reactions to the drug. As carbutamide continued to 'look good,' we expanded all phases of the investigation. The clinical trial was increased to include more than 10,000 patients. It was only after the larger test was put into effect that adverse reports began to be heard from the field.

"We share the disappointment of many diabetics. They had hoped that carbutamide would be the long-sought answer to the need for an oral therapy. We had hoped that through the introduction of carbutamide in the United States we could add to our long list of contributions to diabetes therapy which began with the first commercial insulin preparation in January, 1923."

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The Woman's Auxiliary

REPORTS TO I.S.M.A.

MRS. ROBERT ACHER

Mrs. Robert Acher of Greensburg has been named State Safety Chairman for the Woman's Auxiliary to I.S.M.A. I have asked her to discuss her program this month inasmuch as safety, both on the highway and in the home, is a problem of real concern to every family.

Mrs. Acher writes:

SAFETY PROGRAM FOR COUNTY MEDICAL AUXILIARIES

One of the specific public relations projects adopted for 1957 by the Woman's Auxiliary to A.M.A. is a safety committee.

The program that was given at our State Auxiliary meeting in October by Sgt. Elmer C. Paul, Indiana State Police, made us cognizant of the fact that a safety program is imperative. We think this same program, which Sgt. Paul said was available, would be excellent for us to sponsor in our own communities.

We, as doctors' wives, are made acutely aware of the need for a safety program as we see our husbands rush out on emergency calls as the result of accidents. The Auxiliary program does not confine its activities to highway and traffic, but also stresses educational programs on safety in the home.

In the important lexicon of health, there is no more potent word than safety, and this is pointed up in the "ABC's of Safety" set by a national committee:

(A) Safety in the Home

(B) Safety in the School

(C) Safety on the Highway

We hope to include the following procedures in our County Auxiliary Programs:

1. Appoint a safety committee and chairman.
2. Make one Auxiliary meeting a Safety meeting using films, speakers and other means of stressing the safety theme.
3. Support the resolution adopted by the A.M.A. House of Delegates urging the President of the United States to ask for Congressional legislation for the appointment of a national body to approve and regulate safety standards and automobile construction.
4. Stress the danger of speed and publicize the motto "Heed, not Speed".
5. As individuals work with the safety committees in our schools.
6. Obtain outstanding films and offer them to our P.T.A. groups, service clubs, and church youth groups.

We plan to work together for the safety of all citizens.

Mrs. Robert Acher, State Safety Chairman
446 East Washington Street
Greensburg, Indiana

Assistance in setting up county level meetings is available. Just contact Mrs. Acher for additional information.

Julia Tindall

MRS. WILLIAM R. TINDALL, *President*

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DONALD H. KENNEDY, *Executive Director*

Tom Hendricks Takes New Post as Field Director for A.M.A.

THE BOARD OF TRUSTEES has announced the appointment of Thomas A. Hendricks, who has been serving as secretary of the A.M.A. Council on Medical Service, to the newly-created position of field secretary.

Mr. George Cooley, who has handled much of the Council's heavy load of work as associate secretary, was named acting secretary of the Council.

Tom will serve in a two-way communications job: 1. As field representative from the secretary's office in Chicago headquarters, he will interpret A.M.A. policies and programs for state and county medical societies; 2. By virtue of his accessibility in the field, he will be an important link in the communications chain between state and county medical societies and the A.M.A. Through him another avenue is available for transmitting to A.M.A. headquarters and the Board of Trustees up-to-the-minute reports on local problems and attitudes.

Mr. Hendricks has had a long career in the field of medicine. Before joining the A.M.A. in 1945, he served many years as executive secretary of the Indiana State Medical Association. He has been a medical executive for 32 years. Prior to that time he had a colorful career on three Indianapolis newspapers and as a radio sports broadcaster. It was then that he played tournament tennis with Bill Tilden, rode the Indianapolis Motor Speedway with Champion Ralph DePalma, and covered the great Ohio flood in 1937 with Westbrook Pegler. In his boyhood he played with Cole Porter, and when he graduated from Princeton in 1915 he was proud of a classmate, Jim Forrestal, first Secretary of Defense. He knew Booth Tarkington and Bill Herschell, who inherited Riley's mantle as the "Hoosier Poet." He also knew intimately Cartoonist Gaar Williams and Kin Hubbard, creator of "Abe Martin." His meetings with Meredith Nicholson, George Ade and Senator Albert Beveridge, the Lincoln biographer, were frequent.

And, among other things, Tom served 10 years in the Indiana legislature—one term in the House and two in the Senate.

He is taking over his new duties immediately.

—George F. Lull, M.D.
in A.M.A. Secretary's Letter

GIVE GENEROUSLY

TO A.M.E.F.

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Oak Ridge Institute Schedules Series of Thyroid-Uptake Seminars

The Medical Division of the Oak Ridge Institute of Nuclear Studies has announced that it will present a series of six thyroid-uptake seminars this winter and spring, to provide instruction in a standard method of calibrating the uptake of radioiodine by the thyroid. Two of the sessions will be open to invited physicians and physicists; two will be open to all other qualified physicians and physicists; one will be designed for manufacturers' representatives; and one will be open to qualified technicians.

The following four open seminars have been scheduled:

Seminars 1 and 2: March 18-19 and April 15-16. Open to qualified physicians and physicists who have not participated in the thyroid-uptake calibration survey, each of these seminars will accommodate a total of 30 persons, with a maximum of 15 physicists. A $25.00 fee will be charged, and the program will be the same as for Seminars A and B.

Seminar 3: May 17. This seminar will be open only to representatives of manufacturers of thyroid-uptake equipment. A maximum of 60 participants will be accepted, and a $25.00 fee will be charged. The program will be similar to that for the previous seminars, with laboratory sessions omitted.

Seminar 4: June 10-14. A total of 30 technicians employed under the direction of physicians who have attended one of the previous seminars will be accepted in this experimental seminar, which will train technical assistants for work with professional staff members. A fee of $50.00 per person will be charged.

Further information concerning any of the seminars, and application forms, may be obtained by writing Mr. William Busby, ORINS Medical Division, P. O. Box 117, Oak Ridge, Tennessee.

All Members of the
Indiana State Medical Association
are cordially invited to attend the

ANNUAL SCIENTIFIC SESSION OF THE

INDIANA CHAPTER
AMERICAN COLLEGE OF SURGEONS

WEDNESDAY, APRIL 24, 1957
8:30 a.m. TO 4:30 p.m.

Speakers will include Drs. I. F. Ravdin, George Crile, Bronson Ray, Herbert Schmitz, Harris Shumacker and many others.

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Mary F. Hamilton, M.D., Associate

Deaths . . .

John Tilden Samples, M.D., 78, practicing physician at Boonville since 1907, died November 1 in Deaconess Hospital, Evansville, following a long illness.

Dr. Samples was born in Warrick county and taught school there for eight years before entering Kentucky School of Medicine from which he received his degree in medicine in 1907. He had been in practice in Boonville since that time with the exception of service during World War I when he served overseas as a major. He had been an active member of the American Legion, and also held church and lodge memberships.

Dr. Samples was a senior member of the Indiana State Medical Association, and was a member of Warrick County Medical Society and the American Medical Association.

Michael Pulver, M.D., 51, a practicing surgeon at the Veterans Administration Hospital in Fort Wayne, died suddenly of a heart attack November 7 in his home on the hospital grounds.

Dr. Pulver was born in New York City and received his medical degree in 1931 from New York Medical College. He was a practicing surgeon in New York City until he was appointed to the VA staff in 1953.

Dr. Pulver was a member of American Medical Association.

Grover Cleveland Dunham, M.D., 72, died November 15 at his home in Kempton from a coronary occlusion. He had recently celebrated his fiftieth anniversary as a physician in Tipton county.

Dr. Dunham was graduated in 1906 from the Indiana Medical College, School of Medicine, Purdue University, Indianapolis.

Grover A. Smith, M.D., New Haven, died November 17 in Parkview Hospital, Fort Wayne, where he had been taken after suffering a stroke in his home. He would have celebrated his seventy-first birthday the following day.

Dr. Smith was born in Hoagland and taught school for two years before entering Eclectic Medical College, Cincinnati, where he received his medical degree in 1911. He practiced for 12 years in Bryant during which time he served a term as Jay county coroner, and then established his practice in New Haven where he had been for 33 years.

During World War I Dr. Smith served in France with a field hospital, holding the rank of captain. He held church, fraternal and patriotic organization memberships.

He was a member of the Allen County Medical Society, the Indiana State and American Medical Associations.

Among survivors are two sons, Richard B. Smith, M.D. and Roger C. Smith, M.D., Fort Wayne, and a brother, W. O. Smith, M.D., Hoagland.

I. Herman Sloss, M.D., 71, Terre Haute physician for 35 years, died in St. Anthony's Hospital in that city November 19 following a long illness.

Dr. Sloss was born in Franklin, Kentucky and received his medical education at Meharry Medical College where he obtained his degree in 1911. He practiced for a number of years at Princeton, Kentucky. In 1950 he established a hospital and clinic in Terre Haute.

For many years Dr. Sloss had been a member of Vigo County Medical Society, the Indiana State and American Medical Associations. He held church and lodge memberships.

Bruce D. Lung, M.D., 68, a practicing physician in Kokomo since 1914, died November 24 in his home. He had been in ill health since April and confined to his home since late September.

Dr. Lung was a native of Carroll county. He was graduated from Indiana University School of Medicine in 1913 and had been in practice in Kokomo since. During World War I he served as a first lieutenant in the army. He was Howard County coroner for three terms.

Dr. Lung had been active in medical organizations, having served as Howard County Medical Society president. In addition to his county

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society he also held memberships in the Indiana State and American Medical Associations and the American Academy of General Practice. He was a charter member and past president of Kokomo Rotary club and held membership in religious, fraternal, patriotic and sport organizations. He was interested in all sports and twice was Kokomo bowling champion.

Elbert S. Waymire, M.D., 70, Indianapolis, died December 4 in his home.

Dr. Waymire was born in Miami county and was a graduate of Indiana University School of Medicine where he received his degree in 1910. Following internships at Methodist Hospital, Indianapolis, and the Wabash Railroad Employees Hospital, Peru, he established an office in Denver in Miami county in 1912. Dr. Waymire served as a first lieutenant in the medical corps in World War I. He moved to Indianapolis in 1925 and had been in practice in that city since.

Dr. Waymire held numerous lodge memberships and was a member of Indianapolis Medical Society, the Indiana State and American Medical Associations.

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

March 5, 6, 7 and 8, 1957

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Helpful and time-saving Technical Exhibits

The Chicago Medical Society Annual Clinical Conference should be a MUST on the calendar of every physician. Plan now to attend and make your reservations at the Palmer House.

NEWS NOTES—from State and Nation

I.S.M.A. Delegates and Members Attending A.M.A. Session Listed

Registration lists published during the Seattle Clinical Session of the American Medical Association include the names of Drs. E. S. Jones, Hammond, Cleon A. Nafe, Indianapolis, and Wendell C. Stover, Boonville, delegates; Walter L. Portteus, Franklin, alternate delegate; Lester D. Bibler, Indianapolis, delegate from the Section on General Practice; and Lall G. Montgomery, Muncie, delegate from the Section on Pathology and Physiology.

Other Indiana physicians registered were Drs. Philip A. Boyer, Jr., Indianapolis; F. S. Crockett, West Lafayette; Howard G. Glass, Elkhart; Wilbur J. Irish, East Chicago; Gerald J. Kohne, Decatur; Robert K. S. Lim, Elkhart; Harold C. Ochsner, Indianapolis; Roscoe L. Sensenich, South Bend; Herbert P. Sloan, New Albany; W. D. Snively, Jr., Evansville; M. C. Topping, Terre Haute; A. Baptisti, Jr., Indianapolis; Harry E. Voyles, New Albany; James Glenn, Sheridan; and F. B. Kantzer, Garrett.

James A. Waggener, executive secretary of I.S.M.A., also attended the Seattle meeting.

Five Indiana firms had technical exhibits at the Tenth Clinical Meeting of the A.M.A. in Seattle November 27-30. They were the Ames Company, Inc., Elkhart; Eli Lilly and Company, Indianapolis; Mead Johnson and Company, Evansville; Pitman-Moore Company, Indianapolis; and Zimmer Manufacturing Company, Warsaw.

The twentieth annual meeting of **The New Orleans Graduate Medical Assembly** will be held on March 11 to 14 in the Municipal Auditorium. Information about the program and the post-clinical air tour of Europe and the Mediter-

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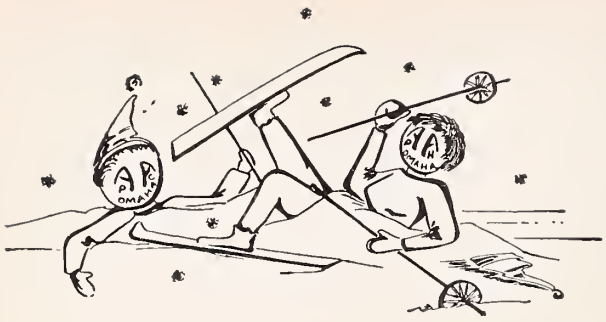

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ranean may be obtained by addressing Dr. Maurice E. St. Martin, 1430 Tulane Ave., New Orleans.

Illinois Announces First Congress on Maternal Care

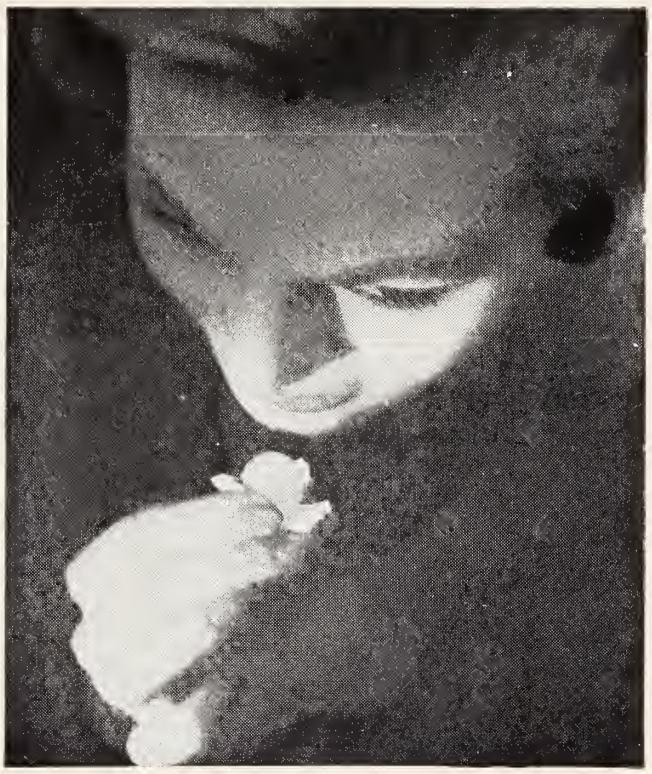
Members of the Indiana State Medical Association have been invited to attend the First Illinois Congress on Maternal Care. The meeting will be held in the Hotel St. Nicholas, Springfield, on February 13 and 14. The program will consist of panel discussions, breakfast conferences and round tables. General practitioners, obstetricians, pediatricians, anesthesiologists, nurses, hospital administrators and other specialists will participate.

A two-day **postgraduate course in ophthalmology** will be held at the Ohio Union Building, Columbus, Ohio, on March 4 and 5. The registration fee is $20.00. Registration by mail is desirable. Further information may be obtained by addressing William H. Havener, M.D., Department of Ophthalmology, University Hospital, Columbus, Ohio.

Dr. Jack A. Bush, who has been in practice in West Lafayette for the last three years, left November 20 for Great Lakes, Illinois, where he was to be inducted into the Navy.

Dr. Gregorio Oclander, a native of Argentina and a specialist in pediatrics, has joined the medical research cooperation division of Eli Lilly and Company, Indianapolis. He will participate in the firm's export program in the fields of pediatric medicine, vitamins, and nutritional factors and will contribute to Lilly's Latin-American publications. Dr. Oclander has been in the United States since 1953 and has been associated with another pharmaceutical firm. He is a member of the New York Academy of Sciences, Argentine Medical Association and Argentine Pediatric Association.

The **Tenth Inter-American Congress** of the Pan American Medical Association will be held in Mexico City, April 15 to 21, 1957. The scientific sessions will begin on Monday the



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15th at 9:00 A.M. The Congress will be held in sections covering all branches of medicine. There are 42 sections including a new "Section on General Practice". Information may be obtained from the Executive Director, Dr. Joseph J. Eller, 745 Fifth Avenue, New York City.

Mayo Clinic, Foundation to Present Clinical Reviews

A three-day program of lectures, discussions and demonstrations on problems of current interest in general medicine and surgery will be presented again this year by staff members of the Mayo Clinic and the Mayo Foundation for Medical Education and Research.

There are no fees for the program which will be presented April 1, 2 and 3 in Rochester, Minnesota.

Up to 21 hours of Category I credit may be obtained by members of the American Academy of General Practice who attend.

Registration is necessarily limited by accommodations. Those wishing to attend should communicate with Mr. R. C. Roesler, Mayo Clinic, Rochester, Minnesota.

Dr. E. B. Call Retires from Practice at Knightstown

After 48 years in the practice of medicine, Dr. Earle B. Call closed his offices in Knightstown November 1.

Dr. Call was born near Rushville and returned to that community immediately after receiving his medical degree from the Indiana Medical College, School of Medicine of Purdue University at Indianapolis in 1907. He has had offices in just two locations during his 48 years in Knightstown.

Upon his retirement Dr. Call donated his supply of drugs for use by the Indiana Soldiers and Sailors Children's Home.

He had been a member of Henry County Medical Society, the Indiana State and American Medical Associations throughout his career.

Dr. Claude Thompson, who received his discharge from the U. S. Air Force in September, began the practice of medicine November 28 in Waynetown in the remodeled former offices

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Salicylamide	150 mg.
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of Dr. F. Dale Johnson, who was forced to suspend practice because of ill health. He had been in Waynetown for 18 years and will continue to reside there.

Dr. Thompson is a native of Rockville and a 1953 graduate of Indiana University School of Medicine. After serving his internship at Indianapolis General Hospital, he entered service. During his two years in service he spent 20 months in Japan. For the present Dr. Thompson will have an apartment at his office.

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The Suction Socket Prosthesis, one of the most important prosthetic developments in recent years, is based on entirely new conceptions of design. Secured solely by muscular and suction action, and eliminating the hip joint and all belts and straps, this prosthesis gives the wearer greater comfort, control, and utility than ever before.

We attribute our proven record of 90% succesful Suction Socket applications to: careful examination, since not all amputations are suited to this type of prosthesis; and correct fitting, in order to retain the suction action yet avoid discomfort. HANGER clients are examined and fitted by "Certified Suction Socket Fitters", certified after examination by a Certification Board composed of representatives of the industry and orthopedic surgeons.

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5,000 Family Physicians to Attend March 25-28 Meeting in St. Louis

More than 5,000 of the nation's family physicians are expected to attend the Ninth Annual American Academy of General Practice Scientific Assembly, March 25-28, 1957, in Kiel Auditorium, St. Louis.

During the four-day scientific meeting, the doctors will hear outstanding speakers discuss important subjects including infertility, polio vaccination, and the "neglected" pediatric areas, the eyes, ears, and feet. They will visit 60 scientific and 260 technical exhibits.

Dr. I. S. Ravdin, professor of surgery at the University of Pennsylvania, will moderate a panel discussion of pre- and post-operative care. Dr. Philip Thorek, associate professor of surgery, University of Chicago, and professor of surgery at Cook County Graduate School, will discuss "Intestinal Obstruction." Three other surgeons will highlight advances in vascular, thoracic, and neurosurgery. One afternoon will be devoted to a review of procedures that assure birth of "healthy babies" from "well mothers".

The Academy's policy-making Congress of Delegates will convene at 2 p.m., Saturday, March 23. All sessions of the Congress and many social functions will be held in the Sheraton-Jefferson hotel.

Wednesday evening, March 27, following induction ceremonies for Academy President-elect Malcom E. Phelps, El Reno, Oklahoma, more than 3,000 guests will attend a President's reception and dance honoring J. S. DeTar, M.D., Milan, Mich., president of the Academy.

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Symposium on "Constructive Medicine in Aging" Announced

The third annual Merrell Symposium on "Constructive Medicine in Aging: Cardiovascular Disorders in the Aged" will be presented in the Netherland Hilton Hotel, Cincinnati, on January 17 from 9:30 a.m. to 4:30 p.m.

The symposium will be moderated by Dr. Johnson McGuire, professor of clinical medicine and director of the cardiac laboratory, University of Cincinnati College of Medicine.

Physicians interested in the problems of aging are invited to attend this symposium which is presented as a service to the medical profession and is an important part of Merrell's continuing program of research in gerontology.

The following speakers and their subjects have been listed:

K. J. Franklin, The Medical College of St. Bartholomew's Hospital, London, "Investigation of What Is Considered Normal for the Aging Cardio Vascular System"; J. Earle Estes, Jr., Mayo Clinic, Rochester, Minnesota, "Venous Disorders in Older People"; Walter S. Priest, associate professor of medicine, Northwestern University School of Medicine, Chicago, "Anticipation and Management of Cardiac Decompensation"; Jessie Marmorston, professor of experimental medicine, University of Southern California, Los Angeles, "Hormonal Aspects of Myocardial Infarction in Female and Male Subjects"; Ancel Keys, professor of physiology and director of the laboratory of physiological hygiene, University of Minnesota, Minneapolis, "Calories and Cholesterol"; Robert W. Wilkens, professor of medicine, Boston University School of Medicine, Boston, "Drug Therapy for Hypertensive Vascular Disease in Patients Past Midlife"; Robert A. Bruce, associate professor of medicine, University of Washington School of Medicine, Seattle, "Evaluation of Functional Capacity in Patients with Cardiovascular Disease"; and Edward J. Stieglitz, consultant in geriatrics, Veterans Administration and St. Elizabeth's Hospital, Washington, D. C., "Integrated Unity of the Patient".

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Dr. Charles A. Bonsett to Practice Clinical Neurology

Dr. Charles A. Bonsett, who recently completed a three-year residency in neurology at Indiana University Medical Center, opened an office at 902 Hume Mansur Building, Indianapolis, on January 2, where he will specialize in clinical neurology. In confining his practice to the clinical phase of neurology, Dr. Bonsett will be pioneering in this field in Indiana.

A native of Indianapolis, Dr. Bonsett started his pre-medical training at Butler University, then entered the army for four years. On his return he re-entered Butler and received his Bachelor of Science degree there in 1949. He then entered Indiana University School of Medicine where he was graduated in 1952. Dr. Bonsett served his internship at Methodist Hospital, Indianapolis,.

Dr. and Mrs. Bonsett have one young son. They live at 3014 Elmhurst Drive.

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Dr. David Lozow has opened offices at 3939 Meadows Drive, Indianapolis, where he will practice orthopedic surgery. He is a graduate of Indiana University School of Medicine, interned at General Hospital and took postgraduate work at New York City's Hospital for Joint Diseases and at Columbia University. Dr. and Mrs. Lozow and their two children live at 7510 East 52nd Street, Indianapolis.

Indianapolis Surgeon Heads Orthopedic Society

Dr. J. Neill Garber, Indianapolis orthopedic surgeon, has been elected president of the American Clinical Orthopedic Society, a group of more than 300 orthopedic surgeons from throughout the Central States. Dr. Garber was elected at the Society's recent convention in Cleveland and will serve during the coming year.

Bunts Educational Institute Offers February Courses

The Frank E. Bunts Educational Institute, affiliated with the Cleveland Clinic Foundation, will present the fourth annual course entitled "General Practice" on February 6 and 7, 1957. Open to all physicians, the course is sponsored by Cleveland chapter, American Academy of General Practice, and is approved for 10 hours credit. Registration is $15.00 and reservations should be addressed to the Registrar, 2020 East 93rd Street, Cleveland 6, Ohio.

On February 27 and 28, the Bunts Educational Institute will present a course on "Otolaryngology" for general practitioners and specialists in otorhinolaryngology. That fee is also $15.00 and reservations should be made with the Registrar at the above address.

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

November 15, 1956

Roll call showed the following present: James W. Denny, M.D., chairman; E. H. Clauser, M.D.; M. C. Topping, M.D.; Wemple Dodds, M.D.; O. W. Sicks, M.D.

Frank B. Ramsey, M.D.; Albert Stump and Robert Hollowell, attorneys; James A. Waggener, executive secretary.

Guest: Bertram Groesbeck, M.D., director, Indiana State Department of Health.

Administration of Expanded Social Security Program

Dr. Groesbeck appeared before the committee, stating that the Governor had forwarded to him the letter from the Association in which the Association asked for the opportunity to discuss with the proper official the administration of the total and permanent disability phase of the extended Social Security program. Dr. Groesbeck stated that the determination had not been definitely made as yet; there was some thinking that it would be placed under the Department of Public Instruction to be administered by the Department of Rehabilitation, which is a part of the Department of Public Instruction. Dr. Groesbeck stated that while he is not necessarily interested in having the program placed in his department for administration, he felt that it should be handled by a department familiar with medical and hospital affairs. After a lengthy discussion the matter was left for further discussion when and if the State made a final determination as to who is to administer the program.

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Membership Report

Number of members November 15, 1956 ___ 4,042*
Number of members November 15, 1955 ___ 3,943
Gain over last year _____ 99
Number of members December 31, 1955 ___ 3,975

* Includes 92 in military service (gratis)
143—$10 members (residents and interns)
288—senior members
74—members, dues remitted by Council
2—honorary members

Number who have paid AMA dues:
November, 1956 _____ 3,852**
November, 1955 _____ 3,746
Gain _____ 106

** Includes 628 exempt members (gratis)—
393 prior to January 1, 1956;
235 so far this year

178—1956 ISMA members are delinquent in payment of 1956 AMA dues.

Legislative Matters

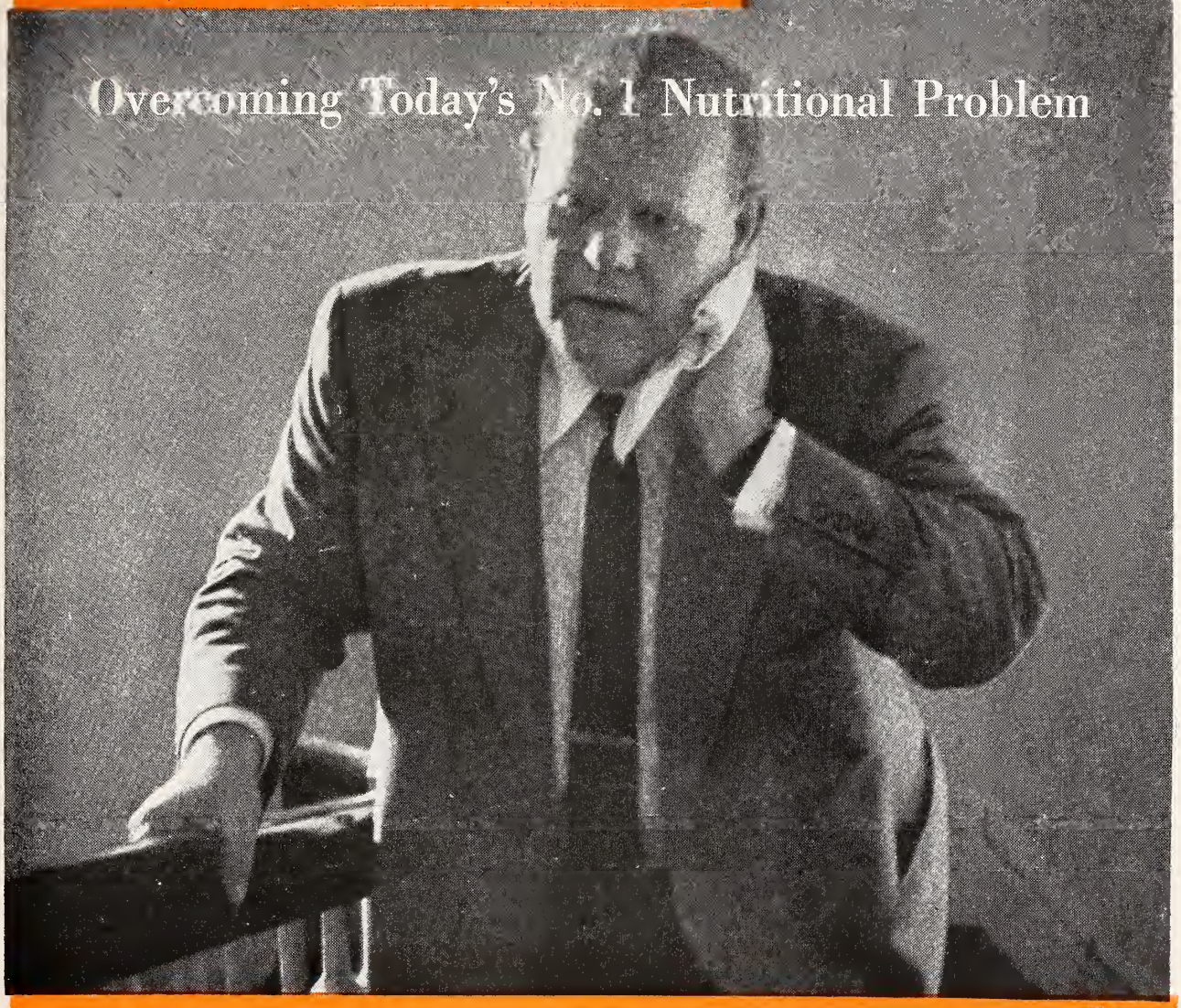
Local. The secretary informed the committee that he had been contacted by representatives of the Funeral Directors' Association who suggested that the Association might sponsor legislation to require coroners to be physicians, and that the Funeral Directors' Association would be happy to support such legislation.

A report of the legal counsel was also presented which pointed out that such a change would necessitate either a Constitutional amendment or separate legislation setting up an office and stripping the present coroner of his responsibility. On motion of Drs. Dodds and Topping, this matter is to be referred to the Council.

Annual Convention, French Lick, October 6-9, 1957

The secretary reported that he had been in contact with the hotel in an effort to find a method of handling exhibits rather than using the lobby. He reported that the hotel had said there would be a

KNOX PROTEIN PREVIEWS



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3. Diets promote accurate adjustment of caloric levels to the special needs of the patient yet allow each individual considerable latitude in the choice of foods.

4. More than six dozen appetizing, low-calorie recipes are presented on the last 14 pages of each diet booklet.

1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

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minimum charge of $4,000.00 for using the convention hall and that there was not suitable ground area to permit pitching of tents. Upon motion of Drs. Topping and Dodds the secretary was instructed to use the lobby.

Organization Matters

Medical examinations in disability insurance program. A letter was read from the Department of Health, Education and Welfare which stated the Department was interested in the recommendation made by the secretary during a visit in their office October 31. The recommendation was the policy adopted by the Executive Committee in recommending the establishment of panels of physicians at county or regional levels for the purpose of certifying the degree of disability of applicants under this program. This was originally presented as a recommendation of Dr. Eleanor P. Cheydleur of Evansville. The letter stated that they were interested in discussing this further and wanted to know when it would be convenient for representatives of the Association to meet with the officials of the department for further discussion. Upon motion of Drs. Sicks and Dodds the secretary was asked to make an appointment and go to Washington for further discussion of this matter.

The secretary presented the minutes of the meeting of the Indiana Inter-Professional Committee on Eye Care held September 30, 1956, which were ordered filed.

The secretary also presented the minutes of the meeting of the Board of Directors of the North Central District Blood Bank Clearing House, dated October 8, 1956, which were ordered filed.

A letter from Dr. F. S. Crockett expressing appreciation to the Association for the honor conferred upon him, and his election as an honorary member, was read to the committee.

The secretary presented the proposed poster which is to be distributed to the schools throughout the state, calling attention to the forthcoming Science Fairs and giving the association credit for its participation.

Medical Care of Military Dependents. Mr. Hollowell reviewed the contract negotiations for Medicare in detail, calling attention to the many changes which had been made in the contract submitted by the Government covering this program.

Meetings

Letter from Dr. Jack M. Mosier regarding payment of his expenses to the American Medical Association's Third Annual Conference on Mental Health was approved, providing the A. M. A. does not reimburse Dr. Mosier, on motion of Drs. Dodds and Clauser.

Letter presented from the American Medical Association soliciting the opinion of the Association regarding holding a meeting of state chairmen of Veterans' Affairs Committees for the purpose of reviewing developments in the A. M. A. policy on a possible date in January, 1957. On motion of Drs. Clauser and Dodds the secretary was instructed to notify the A. M. A. that they thought it would be a good idea to hold such a meeting.

The Committee agreed to meet in joint session with the Executive Committee of the Blue Shield Plan on Sunday, November 18, 1956, at 12:15 p. m., at the Indianapolis Athletic Club.

There being no further business the Committee adjourned to meet again in regular session at 3:00 p. m., Wednesday, December 12, in the headquarters office, 1021 Hume Mansur Building, Indianapolis, Indiana.

An Indian had gone to see the doctor, who, after examining him, told him to be careful about what he ate— in fact, not to eat at all until he got an appetite. Meeting the Indian a few days later, the doctor asked how he felt.

"Oh, I feel fine now," he replied. "I wait one day, appetite no come, wait two day, appetite no come, wait three day, appetite no come, get so hungry eat anyway."

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News from the County Societies

Boone County Medical Society members met December 4 in Witham Memorial Hospital, Lebanon, for the annual election of officers and a scientific program on "Anticoagulants" presented by Dr. Bennett Harvey and Mitchell Woodfall.

The 13 members named Dr. Ritchie Coons, Lebanon, president for the coming year; Dr. Harvey D. Lovett, Whitestown, vice-president; and reelected Dr. Margaret A. Bassett, Thorntown, secretary-treasurer. Dr. C. G. Kern, Lebanon, is delegate to I.S.M.A. and Dr. Coons, alternate delegate.

Dr. R. J. Morrical, Logansport, was elected president of **Cass County Medical Society** at the annual dinner meeting December 3 in the Ben Hur restaurant, Logansport. Serving with him during 1957 will be Dr. Bernard R. Hall, Logansport, vice-president; and Dr. Jay M. King, Logansport, secretary-treasurer.

Kenneth W. Bush, field representative for ISMA, gave a report on the Medicare plan for dependents of military personnel. A film was also shown on "Male Sex Hormone" through the courtesy of Schering Corporation.

Thirty-eight persons attended the dinner, including members of the Woman's Auxiliary and several special guests.

The society gave approval to formation of a Cass-Carroll County Medical Assistants organization. The proposed constitution for the group was presented to the society for study.

Dr. L. J. Hillis was renamed delegate to ISMA and Dr. E. L. Hedde will be alternate delegate.

Fayette-Franklin County Medical Society met November 13 in the Connersville Country Club for dinner and a scientific program.

Dr. Hunter Soper and Dr. Warren Coggeshall, Indianapolis, presented a discussion on

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- TELEX Hearing Aids range in price from $99.00 to $279.00, meeting the needs of all types of hearing losses.
- Custom ear molds are made at no extra charge with each hearing aid fitted. Bone conduction fitting, small additional charge.
- Convenient time payments are available.

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"Indications for Cardiac Surgery". Sixteen members attended and made plans for a hospital staff meeting on November 27 when they were to hear an ISMA representative discuss the new medical care plan for military dependents.

A noon luncheon meeting of the **Fountain-Warren County Medical Society** was held in the Attica Hotel December 3 for the purpose of hearing Kenneth Bush, ISMA field representative, outline the Medicare plan and how it will affect members of the medical profession in Indiana. Eight members were present.

Dr. Edward M. Humphrey, medical director of the Olin Works Film Division of Olin-Mathieson Chemical Corporation at Covington, was voted into active membership in the society.

Announcement was made that members and their wives would be guests of Dr. and Mrs. John E. Fisher in Attica for the January 3 meeting.

"The Relationship Between Religion and Medicine" was the topic of a talk given by the Rev. E. D. Greenfield to 13 members of the **Gibson County Medical Society** on November 14. The meeting was held in the Emerson Hotel in Princeton.

Dr. A. W. Records, Franklin, has been named president of **Johnson County Medical Society** and will assume office January 1. Dr. Robert H. K. Foster becomes president-elect and chief of the Johnson County Hospital staff for 1957. Dr. Woodrow W. Stogsdill, also of Franklin, is the new secretary-treasurer.

Dr. Mitchell J. Netchtow, Chicago gynecologist, was the guest speaker at the November 15 dinner meeting of the **LaPorte County Medical Society** in the Hotel Rumely, LaPorte. His paper on "Practical Gynecology" was reported as exceptionally interesting.

Forty-three reservations were made for the dinner, including wives of the members.

Dr. Robert J. Frost, Michigan City, discussed "Problems of a Pathologist" at the business meeting. The society authorized a donation to the National Society for Medical Research, and voted to assist in sponsoring a science fair in the area again this spring. The Woman's Auxiliary has been invited to dine with the society each month.

Ruel Steele, Bedford attorney, spoke on "Interprofessional Ethics" before a meeting of the **Lawrence County Medical Society** in Dunn Memorial Hospital, Bedford, on November 7. County attorneys were special guests of the society at the luncheon meeting. Eighteen doctors and 11 guests attended. A general discussion of problems affecting both the medical and legal professions followed. A committee composed of Drs. R. B. Smallwood, D. M. Kerr and Kendrick Edmonds was named to work with the attorneys on formulating a code under which the two professions would operate.

Members of the **Madison County Medical Society** were guests of the management of the Delco-Remy division of General Motors in their Plant One cafeteria in Anderson November 19.

Guest speaker for the evening was Dr. Earl F. Lutz, associate medical director of General Motors, who told the 74 members present "Industry has learned that it is economically sound

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to keep every employee as healthy as possible and, as a result of the viewpoint, industry is continually improving working conditions and health safeguards". In keeping with his theme of "Relationship Between the General Practitioner and the Industrial Physician", Dr. Lutz emphasized how the industrial physician and the family doctor complement each other.

Delco-Remy plant physicians, Dr. Richard C. Swan and Dr. Merrill P. Benoit, were chief hosts. Dr. Swan served as master of ceremonies and introduced several plant officials who spoke briefly.

Dr. Warren E. Fischer, president of the county society, conducted a short business meeting following Dr. Lutz' address.

Dr. Clifford D. Benson, Detroit, and Dr. Cecil Striker, Cincinnati, were guest speakers at the November 13 and 27 meetings of **Indianapolis (Marion County) Medical Society** in the White Cross Guild auditorium at Methodist Hospital.

Dr. Benson, who was introduced by Dr. J. K. Berman, discussed "Anomalies of the GI Tract in the Newborn and Infant". Dr. Striker presented a paper on "Diabetes Mellitus". He was introduced by Dr. I. W. Wilkens.

Physicians elected to membership at the late November meeting were Drs. Francis E. McAree, John I. Nurnberger, transfer from Hartford, Connecticut, George Maniaci, M. Speers McCollum, David Lozow, Thomas W. Dunning, Eldon D. Van Sandt, Leonard Burman, Donald G. White, Jack B. Mershon, Robert C. Coddington, George M. Haymond, a transfer from Kosciusko county, Carolyn L. Dickson, G. E. Widdifield, R. E. Miller, transfer from Cook county, Illinois, Melvin S. Baird, Paul F. Benedict, James R. Brillhart, Wilbur Hicks, Thomas R. Marshall, Robert H. Reid, Anton Schwarz, Harley Palmer, Max Sneary, Robert Morrow, Ross E. Richardson and Stephen D. Sommers.

Several applications for membership were received and referred to the Council for action.

Two slates of candidates subject to the December 11 election of the society were presented.

Marshall County Medical Society members met in the Warana restaurant in Plymouth for a luncheon meeting November 7 with 12 physicians attending.

Dr. James F. Rimel, Plymouth, presented a paper on "The Acute Abdomen" and there was a general discussion of special features in diagnosis of the acute abdomen with presentation of cases and x-ray films. The report of the meeting described the program as both interesting and informative.

Twenty members of **Montgomery County Medical Society** heard a discussion of "Injuries to the Knee" by Dr. William B. Ferguson, Lafayette, at their November 15 meeting in Culver Union Hospital, Crawfordsville.

Dr. John A. Davis, Flat Rock, was elected president for 1957 of the **Shelby County Medical Society** at a meeting December 5 in the W. S. Major Hospital, Shelbyville. Other officers named for the coming year were Dr. J. O. Alden, Shelbyville, vice-president; and Dr. W. L. Dalton, Shelbyville, secretary-treasurer. Dr. Paul R. Tindall was reelected delegate from the society to ISMA, and Dr. Dalton renamed alternate delegate.

A film, "The Doubting Doctor" released through the American Medical Association, was shown following the dinner.

Dr. Khalil G. Wakim of the Mayo Clinic staff at Rochester, Minnesota, was the guest speaker for the November 13 meeting of the **Wayne-Union County Medical Society** in Reid Memorial Hospital, Richmond.

Dr. Wakim spoke on "Nephrosis and the Cause of Albuminaria".

Nine members of **White County Medical Society** met in the White County Memorial Hospital November 13 for the purpose of transacting routine business and electing officers for 1957.

Dr. S. E. McClure, Monon, was named president; Dr. J. C. Carney, Monticello, vice-president; and Dr. David C. Beck, secretary-treasurer.

"The Case of the Doubting Doctor" was shown at the November 13 meeting of **Van-**

(Please turn to Page 130)

You are cordially invited to attend

THE THIRD ANNUAL MERRELL SYMPOSIUM

Constructive Medicine in Aging: Cardiovascular Disorders in the Aged

Thursday, January 17, 1957, 9:30 A.M. to 5:00 P.M.
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PROGRAM

Johnson McGuire, Professor of Clinical Medicine and Director of Cardiac Laboratory, University of Cincinnati College of Medicine, will serve as moderator for the Symposium

K. J. Franklin, The Medical College of St. Bartholomews Hospital, London.
INVESTIGATION OF WHAT IS GONSIDERED NORMAL FOR THE AGING GARDIOVASCULAR SYSTEM

J. Earle Estes, Jr., Mayo Clinic, Rochester, Minnesota.
VENOUS DISORDERS IN OLDER PEOPLE

Walter S. Priest, Associate Professor of Medicine, Northwestern University School of Medicine, Chicago.
ANTICIPATION AND MANAGEMENT OF GARDIAC DECOMPENSATION

Jessie Marmorston, Professor of Experimental Medicine, University of Southern California, Los Angeles.
HORMONAL ASPECTS OF MYOCARDIAL INFARCTION IN FEMALE AND MALE SUBJECTS

Ancel Keys, Professor of Physiology and Director of Laboratory of Physiological Hygiene, University of Minnesota, Minneapolis.
CALORIES AND CHOLESTEROL

Robert W. Wilkins, Professor of Medicine, Boston University School of Medicine, Boston.
DRUG THERAPY FOR HYPERTENSIVE VASCULAR DISEASE IN PATIENTS PAST MIDLIFE

Robert A. Bruce, Associate Professor of Medicine, University of Washington School of Medicine, Seattle.
EVALUATION OF FUNGTIONAL CAPAGITY IN PATIENTS WITH CARDIOVASGULAR DISEASE

Edward J. Stieglitz, Consultant in Geriatrics, Veterans Administration and St. Elizabeths Hospital, Washington, D. C.
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Editorially the first issue of The JOURNAL of the Indiana State Medical Association declared "We are starting out with clean advertising pages. To do so it has been necessary to refuse over two thousand dollars' worth of such advertising as is regularly accepted by some of the most prominent medical journals in the country. But we believe that every right-thinking physician in Indiana will approve our course, as we also believe that very soon every prominent medical journal in the country will have to refuse objectionable advertising or go out of business because all right-thinking doctors will refuse to support or read any journal which publishes nostrum or other objectionable advertising."

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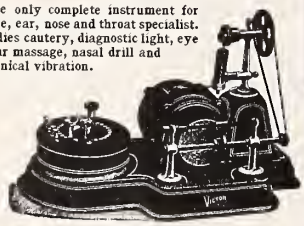

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January 15, 1908

the first issue obsolete. Other advertisements could, and do, appear in modern dress with only slight alteration. Reproduced on these pages are seven advertisements from the January 15, 1908 JOURNAL. Three represent firms or institutions which have been consistent advertisers in The JOURNAL.

In this issue, January 1957, Norways Foundation Hospital, Indianapolis, the Medical Protective Company, Fort Wayne, and Parke, Davis & Company, Detroit, begin their fiftieth year of association with The JOURNAL. During the remaining months of 1957 we will welcome other old friends who through its first 50 years have helped make The JOURNAL of the Indiana State Medical Association a leader among medical publications.

The reliability and stability of JOURNAL advertisers and their products is evidenced by the first advertisement of Parke, Davis & Company. The product in January, 1908, was Taka-Diastase. A leading Indianapolis pharmacy informs us that prescriptions are filled daily for this starch-converting ferment.

Medical Protective Company, established in 1899 and offering professional protection exclusively, today refers to its specialized services as "medical prophylaxis."

Norways, for many years known as Dr. Sterne's Sanitorium for Nervous Diseases, has expanded its facilities at the same lo-

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Medical Protective Company :: Fort Wayne, Ind.

cation, and now treats neurosychiatric disorders by methods unknown 50 years ago. It is sponsored by Norways Foundation, a non-profit organization.

Other advertisements shown on pages 128, 129 and 130 were selected because they were believed to have general interest, product-wise and price-wise. Format of the ads is in interesting contrast to 1957's modern commercial lay-outs with impressionistic art or spectacular photography.

In January 1908, even as today, we notice a typographical error or two. The Centlevre Tonic in January became Centlivre Tonic in February and continued to appear with correct spelling of the old Fort Wayne name.

EENT specialists will look with amazement at the prices of standard surgical instruments in 1908. Many of the Barnhill and Andrews' instruments pictured are still used, however prices have increased from 2 to 15 times in the half century.

Next month other 1908 ads will be reproduced and the March issue will have some information on the first Professional Cards carried as the Physicians' Directory. No March 1908 issue remains in The JOURNAL files—it is not included in the bound volume of that year. If a copy of that issue can be located—and we hope it will be found during this anniversary year—the first volume of The JOURNAL will be rebound to include the missing number.

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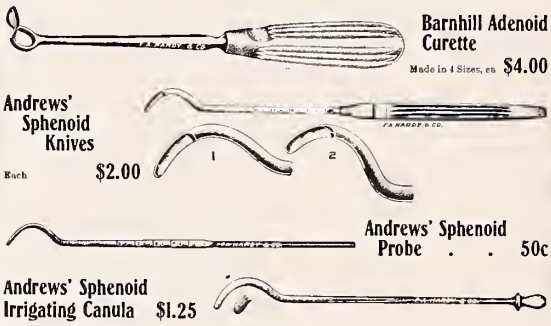

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County Societies (Continued)

derburgh County Medical Society in the Hotel McCurdy, Evansville, and was received with much favorable comment. Dr. Henry Rusche presented a report for the society's delegation to the ISMA annual meeting and after discussion it was suggested that a special meeting be held prior to the state meeting each year to study resolutions to be introduced to the House of Delegates.

The annual dinner dance of the society was held December 6 in the Evansville Country Club.

Annual election of officers was scheduled for December 11.

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Benton	Robert H. Leak, Boswell	Dan Tucker Miller, Fowler
Boone	Ritchie Coons, Lebanon	Margaret A. Bassett, Thorntown
Carroll	Thomas Neal Petry, Delphi	Charles L. Wise, Camden
Cass	R. J. Morrical, Logansport	Jay M. King, Logansport
Clark	George M. Buehler, Jeffersonville	Wm. B. Clark, Jr., Jeffersonville
Clay	John M. Palm, Brazil	Robert K. Webster, Brazil
Clinton	Robert Hedgcock, Frankfort	Frank A. Beardsley, Frankfort
Daviess-Martin	Marshall H. Seat, Washington	C. Philip Fox, Washington
Dearborn-Ohio	Charles W. Olcott, Aurora	Fred D. Houston, Lawrenceburg
Decatur	Louis Walker, Greensburg	James C. Miller, Greensburg
DeKalb	Loren Jinnings, Garrett	H. V. Hippensteele, Auburn
Delaware-Blackford	Anson G. Hurley, Muncie	I. S. Hostetter, 115 N. Cherry St., Muncie
Dubois	Arthur Wagner, Jasper	Elton Heaton, 215 Walnut St., Huntingburg
Elkhart	Elmer G. Koehler, Elkhart	Page E. Spray, Elkhart
Fayette-Franklin	W. A. Kemp, Connersville	J. L. Steinem, 812 Grand Ave., Connersville
Floyd	J. I. Streepey, New Albany	Daniel H. Cannon, P. O. Box 161, New Albany
Fountain-Warren	Carl A. Nelson, West Lebanon	Lowell R. Stephens, P. O. Box 85, Covington
Fulton	K. K. Kraning, Kewanna	Virgil Miller, Akron
Gibson	John K. Folck, Princeton	R. G. Geick, Fort Branch
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Hancock	Wayne Endicott, Greenfield	B. A. Vingis, Greenfield
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Jay	E. M. Gillum, Portland	William Cripe, Portland
Jefferson-Switzerland	Ott B. McAtee, Madison	W. E. Childs, 412 E. Main St., Madison
Jennings	W. H. Stemm, North Vernon (deceased)	John H. Green, North Vernon
Johnson	Arthur W. Records, Franklin	W. W. Stogsdill, 176 E. Jefferson, Franklin
Knox	Robert Byrne, Bicknell	A. A. Sullenger, 605 Busseron, Vincennes
Kosciusko	Ryland Roesch, Warsaw	W. B. Wilson, Mentone
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LaPorte	A. C. Predd, LaPorte	Charles F. Muhleman, LaPorte Ernest P. Messner, Ex. Secy., 117 W. 8th St., Michigan City
Lawrence	Thomas J. Fountain, Bedford	Richard D. Hawkins, 1122 15th St., Bedford
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Marion	James M. Leffel, Indianapolis	Ottis N. Olvey, Indianapolis Mr. Joseph E. Palmer, Ex. Secy. 1017 Hume Mansur Bldg., Indianapolis
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Morgan	James Bivin, Mooresville	Loren F. Taylor, Martinsville
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Posey	John Grist, Mt. Vernon	Herman Hirsch, Mt. Vernon
Pulaski	Thomas E. Carneal, Winamac	Harold J. Halleck, Winamac
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Warrick	Arthur R. Rogers, Newburgh	R. P. Dimmett, Boonville
Washington	W. T. Paynter, Pekin	I. E. Huckleberry, Salem
Wayne-Union	Russell L. Malcolm, Richmond	Charles H. Loomis, 310 Medical Arts Bldg., Richmond
Wells	Richard P. Yoder, Bluffton	P. C. Talbert, Bluffton
White	Stanley E. McClure, Monticello	David C. Beck, Monticello
Whitley	Thomas G. Hamilton, Columbia City	Warren L. Niccum, Columbia City

This summary of what is happening in Washington is prepared by A.M.A.'s capital office and airmailed to THE JOURNAL on the ninth of each month.

THE MONTH IN WASHINGTON

Washington, D. C.—The broad issue of federal construction grants for medical schools pending before the 85th Congress raises again a major question: To what extent is there a physician shortage in the United States?

The administration, through Secretary Folsom, maintains that the need for more doctors and research scientists is increasing rapidly as the population rises, as medical science grows more complex and as research programs are greatly expanded. And, he adds, the need undoubtedly will continue to increase in the years ahead.

Many of these schools already are in a critical financial plight, Mr. Folsom argues, and they need increased private and public funds "just to meet regular operating expenses." Under these circumstances, without further aid, "many schools face almost impossible obstacles in raising funds for construction of new classrooms, laboratories and other facilities." The Secretary then sounds this warning:

"Unless effective action is taken now toward providing these facilities, the shortage of medical scientists will grow much more acute in the years ahead, and the health of the American people will be retarded."

To solve this problem, the administration wants to broaden the program enacted last year for $30 million a year for three years to help build and equip laboratories doing research in various diseases. It asked the last Congress for $50 million a year for five years for both research labs and teaching facilities. The legislators only granted the $30-million-a-year part. That, says the administration, is not enough.

And to bolster that contention, Mr. Folsom cites the record on the lab facilities act: within three months after authorization, requests totalling well over $100 million were received by the Public Health Service.

But when the committees of Congress—in all likelihood starting with the House Interstate and Foreign Commerce group—launch their hearings, members will want to know just how short the country is of doctors and whether reports of shortages take into account the increased productivity of each physician in the light of new techniques and other medical advances.

AMA STUDIES 70 BILLS

On the opening day of the 85th Congress, health legislation emerged as a popular subject. Of the approximately 2,000 bills, resolutions and private measures introduced that day, 70 were marked for study by the Washington Office of the American Medical Association. Experience has shown that about 3% of all measures are of medical importance.

Many of the bills were duplicates of those in the last Congress, while others were revised versions of old favorites. In the latter category were the Jenkins-Keogh bills (again bearing the numbers H.R. 9 and H.R. 10) which would provide tax deferment on money paid in annuity plans, and the Bricker Amendment for keeping international treaties from affecting internal laws of the U. S.

The tax deferment proposal was changed in several respects, the most important being a provision for withdrawal of money from plans in advance of age 65, upon payment of a tax penalty. The key section in the proposed constitutional amendment sponsored by the Ohio Senator states that "A provision of a treaty or other international agreement not made in pursuance of this Constitution shall have no force or effect."

One of the few surprises in the opening day rush to the bill hoppers was a bill by Rep. Poage (D., Tex.) to authorize the Secretary of HEW to make long-term, 3%-interest loans to non-profit hospitals for construction and ex-

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*Bodkin, L.G., and Ferguson, E.A., Jr.: Successful Ointment Therapy for Pruritus Ani, Am. J. Digest. Dis. 18:59 (Feb.) 1951.

The Month in Washington
(continued)

pansion of facilities, including nurses' homes. Certain sectarian groups have been pressing for just such a plan in lieu of taking federal grant money under the Hill-Burton program.

Moving to fill two major spots in the Department of HEW, President Eisenhower has named as Assistant Secretary 36-year-old Elliott L. Richardson, a Boston lawyer and son of the late Dr. Edward P. Richardson of Massachusetts General Hospital and Harvard Medical School. Mr. Richardson served at one time as law clerk to Judge Learned Hand and Justice Felix Frankfurter, as assistant to Senator Saltonstall and as consultant to former Governor Christian Herter, now Under-Secretary of State.

To succeed Dr. Lowell T. Coggeshall as special assistant for health and medical affairs, the President appointed Dr. Aims C. McGuinness, a Philadelphia pediatrician who was last in Washington as a clinical consultant to the United Mine Workers Welfare and Retirement Fund. He was responsible for the medical staffing of the Fund's 10 memorial hospitals in three mining states. Dr. McGuinness was dean of the University of Pennsylvania Graduate School of Medicine and one-time director of Children's Hospital of Philadelphia.

Dr. Coggeshall, who returns to the University of Chicago, was praised by Mr. Folsom for his "splendid work on behalf of the health of the American people."

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Wanted: PHYSICIANS LOCATIONS

As part of the Physician Placement Service of the Indiana State Medical Association through which prospecting physicians and needy communities are brought together, a list of physicians who made inquiry during November and December has been compiled. The physicians have been sent placement booklets listing all communities now seeking a physician. Each community has been sent a copy of the following list of physicians with the suggestion that direct contact be made and an invitation extended to them to visit the communities.

During the two-month period only one new location was reported.

SWEETZER—Grant County; population 800 with large surrounding territory. Located six miles from Marion. Thriving community without a physician. Contact Mr. O. C. Sweet, President, Farmers' Bank, Sweetzer, for details.

Any listed community which has secured the services of a physician is asked to report the name of the physician to the Indiana State Medical Association, 1021 Hume Mansur Building, Indianapolis 4, Indiana.

Robert D. Miller, M.D. (available July, 1957) (general), 5800 S. Stony Island Avenue, Chicago 37, Illinois.

Richard L. Shoemaker, M.D. (available October, 1957) (general), 48 Knox, Bangor, Maine.

Carl A. Trees, M.D. (available summer 1957) (general), 3310 Cowley Way, San Diego 17, California.

Robert B. Wright, M.D. (neurological surgery), 4903 Flanders Avenue, Kensington, Maryland.

Waldo G. A. Edelman, M.D. (public health and preventive medicine), Southfield, Massachusetts.

Sidney Roston, M.D. (internal medicine), 166C Prichard Place, Ft. Knox, Kentucky.

Philip D. Sloan, M.D. (anesthesiology), 2140 McKinley Avenue, Lakewood 7, Ohio.

John R. Anderson, M.D. (radiology), 1275 E. Second Street, Long Beach 2, California.

H. Trees, M.D. (salaried position, group practice in internal medicine), BOQ 50 No. R, Fort Myer, Burlington 11, Virginia.

Sidney L. Schuchter, M.D. (internal medicine), 2744 Noble Road, Cleveland Heights, Ohio

Wayne B. Stone, M.D. (general with psychiatry), Box R, Amarillo AFB, Texas.

Leonard E. Alkire, M.D. (available August, 1957) (general), 5027 48th Street, Sacramento, California.

T. A. Jamieson, M.D. (general), 2800 Lundy's Lane, Niagara Falls, Ontario.

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Extracts of Whole Bile (Equal parts Ox and Hog)	210.0 mg.
Ketocholanic Acids (Oxidized or keto form of normally accurring bile acids containing approximately 93% dehydrocholic acid)	90.0 mg.
Methyl Cellulose	130.0 mg.
Homatropine Methylbromide	2.5 mg.

SAMPLES AND LITERATURE ON REQUEST

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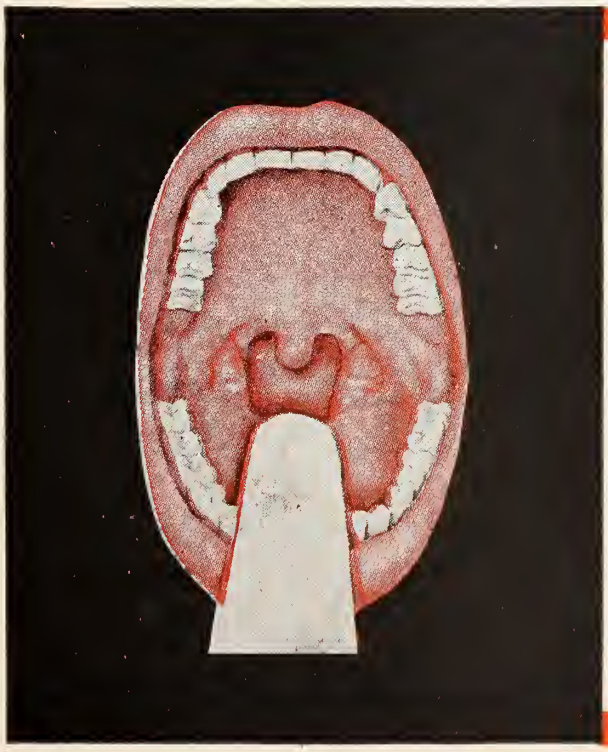

"...effective...in the treatment of a variety of infections seen regularly by the practicing clinician..." including pharyngitis, bronchitis and other respiratory infections

and "... often useful in the treatment of infections due to staphylococci resistant to one or several of the regularly used antibiotics"

"side effects . . . [are] notable by their absence"[1]

1. Carter, C. H., and Maley, M. C.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 51.

Medical Panorama—

A. W. Cavins, M. D.

Terre Haute

FAR MUCH LIKE NEAR

In the medical panorama of the U.S.A. it is interesting to note the problems peculiar to each section of our broad land, but it is more interesting, really, to see how many of our harassments are common to all. Here is a sample from California, published in *Newsletter,* by the Public Relations Committee of the California Medical Association. [Somehow, this has a familiar ring.]

All Members of the
Indiana State Medical Association
are cordially invited to attend the

ANNUAL SCIENTIFIC SESSION OF THE

INDIANA CHAPTER
AMERICAN COLLEGE OF SURGEONS

WEDNESDAY, APRIL 24, 1957
8:30 a.m. TO 4:30 p.m.

Speakers will include Drs. I. F. Ravdin, George Crile, Bronson Ray, Herbert Schmitz, Harris Shumacker and many others.

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If you plan to attend, please notify:
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SITTING IN WITH THE CMA COUNCIL

The CMA Council met in Los Angeles November 10 and devoted a full day to Association business. Among the actions taken were:

Approval of a contract with the Dept. of Defense for the provision of medical, surgical and hospital care to dependents of military personnel. The "Medicare" program requires CMA to encourage physicians to provide their services, on an established fee basis, and to maintain review committees to handle disputes or misunderstandings. CPS will provide fiscal services, receive bills, make payments, etc. Program goes into effect December 8.

Approved a statement on intravenous injections by registered nurses. Statement was prepared in cooperation with hospital and nursing associations.

Approval of a program of cooperation with state and local health officers looking forward to vaccination of all persons up to age 40 with polio vaccine.

Approval of the policies adopted by General Omar N. Bradley and his committee in reviewing veterans' affairs. Committee voted that non-service connected disabilities of veterans should be responsibility of the community rather than of Veterans Administration.

In addition to the four points enumerated, note that their Council "devoted a full day to Association business." *Our* Council does this, too, at regular intervals throughout the year, a fact which is not always sufficiently appreciated by the average member of our State Association.

Aside from this, it is of great interest to appraise the point-of-view shown in the decisions regarding "Medicare," intravenous injections, "polio" vaccine, and veterans' affairs as compared with our own approach to the same problems.

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New Vaccine for Respiratory Diseases Tested by Army Recruits

AN EDITORIAL in the January 5 *Journal* of the American Medical Association said progress already made in the study of virus-caused respiratory diseases indicates that many more problems will be solved "in the foreseeable future."

Two articles in the same *Journal* reported success in developing a new vaccine to combat non-feverish, grippe-like illnesses especially prevalent among military personnel.

The editorial explained that viruses causing these illnesses, which do not include the common cold, have been variously named AD for "adenoid degeneration" or APC for "adenoidal-pharyngeal-conjunctival" in the past, but are now generally labeled adenoviruses.

At least 14 types of adenoviruses have been identified so far. Types 1, 2 and 5 are frequently associated with feverish respiratory infections in young children. Type 3 causes a new disease called pharyngoconjunctival fever, which is seen most frequently in children. Types 4 and 7 cause much of the acute respiratory disease and primary atypical pneumonia seen among adults, and types 6 and 10 cause conjunctivitis (inflammation of the eyelid lining).

NOT ALL INCLUSIVE

The editorial pointed out that the development of simpler laboratory methods has made it easier to identify previously unrecognized viruses, but early hopes that all respiratory diseases of unknown origin could be attributed to the newly recognized viruses have not materialized.

The vaccine described in the two articles was made to combat infections caused by types 4 and 7 adenoviruses. Viruses obtained from patients' throat washings were grown in monkey kidney

Clinical Reviews

MAYO CLINIC
AND
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ROCHESTER, MINNESOTA
APRIL 1, 2 AND 3, 1957

Staff members of the Mayo Clinic and the Mayo Foundation for Medical Education and Research will present again this year a three-day program of lectures, discussions and demonstrations on problems of current interest in general medicine and surgery.

Up to twenty-one hours of Category I credit may be obtained by American Academy of General Practice members who attend.

There are no fees for this program.

The number of physicians who can be accommodated is necessarily limited. Those wishing to attend should communicate with Mr. R. C. Roesler, Mayo Clinic, Rochester, Minnesota.

tissue and then killed by incubating them in the chemical formalin.

The process was described by Maurice R. Hilleman, Ph.D., Mildred S. Warfield, B.S., Salley Anderson, B.S., and Jacqueline H. Werner, M.S., from the department of respiratory diseases, Walter Reed Army Institute of Research, Washington, D. C.

The testing of the vaccine among 600 recruits at Ft. Dix, N. J., was outlined by Drs. Reuel A. Stallones and Ross L. Gauld, both from the Walter Reed Institute, and Mr. Hilleman, Miss Warfield and Miss Anderson.

The vaccine, which caused no side effects among the persons receiving it, was found to be effective beginning one week after the initial injection, they said. It caused a marked reduction in the number of illnesses requiring hospitalization during the second through the fifth weeks after vaccination. And no disease was found among the vaccinated men after the fifth week. It also appeared to reduce the number of persons with mild attacks of illness which would normally not have required hospitalization.

Interestingly enough, antibody development against type 3 adenovirus was found to be as great as that against types 4 and 7, of which the vaccine was made.

The researchers concluded that the vaccine is safe and effective, that only one shot is necessary, and that the vaccine has great potential in military populations with their high rate of respiratory diseases. Evidence regarding the duration of protection was not obtained, and its value among civilian populations remains to be determined, they said.

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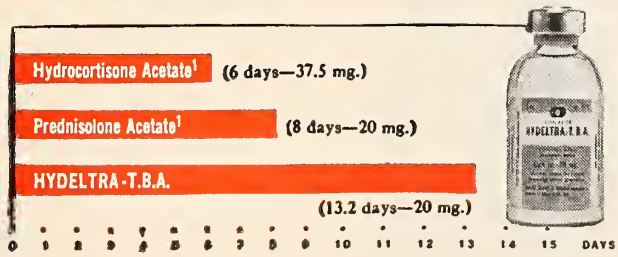

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1. Hollander, J. L., *Paper read at conference in New York City, May 31 and June 1, 1955*

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Books: Reviewed

PULMONARY CARCINOMA: Pathogenesis, Diagnosis and Treatment. Edited by Edgar Mayer, M.D. and Herbert C. Maier, M.D. 18 contributors. 540 pp., fully illustrated. Price $15.00. Published by New York University Press; distributed by J. B. Lippincott Company, East Washington Square, Philadelphia 5, Pa. 1956.

Pulmonary carcinoma is discussed by 18 contributors who are specialists in their field and who are actively engaged in various aspects of work concerning the disease. It is well written and easily readable. There are many good tissue and x-ray illustrations to accompany the subject matter. Modern concepts of the disease are presented and etiological factors are discussed. Heavy smoking is strongly incriminated as one of several probable etiological factors. The various types of malignant disease of the lungs are classified and described and the natural course of the individual type of lesions discussed. In the clinical aspect a "high index of suspicion" is emphasized. The diagnostic results that may be obtained from roentgen, bronchoscopic and exfoliative cytology are presented with the differential aspects of diagnosis. Some of the aspects of surgical treatment with its results are discussed but the reader is not bored with the details of the technique of pulmonary resection. The radiotherapist rather laments the fact that earlier cases have not been available to the radiologist. It is proposed that stage 1 carcinoma of the lung is presumably curable by radiological methods. By and large the radiotherapist presents a fairly optomistic picture of what radiotherapy has to offer in the way of palliation therapy. The offerings of radioisotope and chemotherapy are recorded in individual sections. Chemotherapy followed by radiation therapy has been found to be of particular value in the superior vena cava compression syndrome. The final section of the book is an atlas of case presentations, in which the pitfalls in diagnosis and lessons learned in retrospect, are set forth. The case presentations are very brief and the lessons recorded in one, two, three order.

This book is of particular value to gain an overall picture of the lung cancer problem. It is of interest to the general practitioner, medical specialist and general surgeon. It would be of particular interest to the resident in preparation for assuming a service on chest surgery or medicine. Reading time estimate, 15 to 20 hours.

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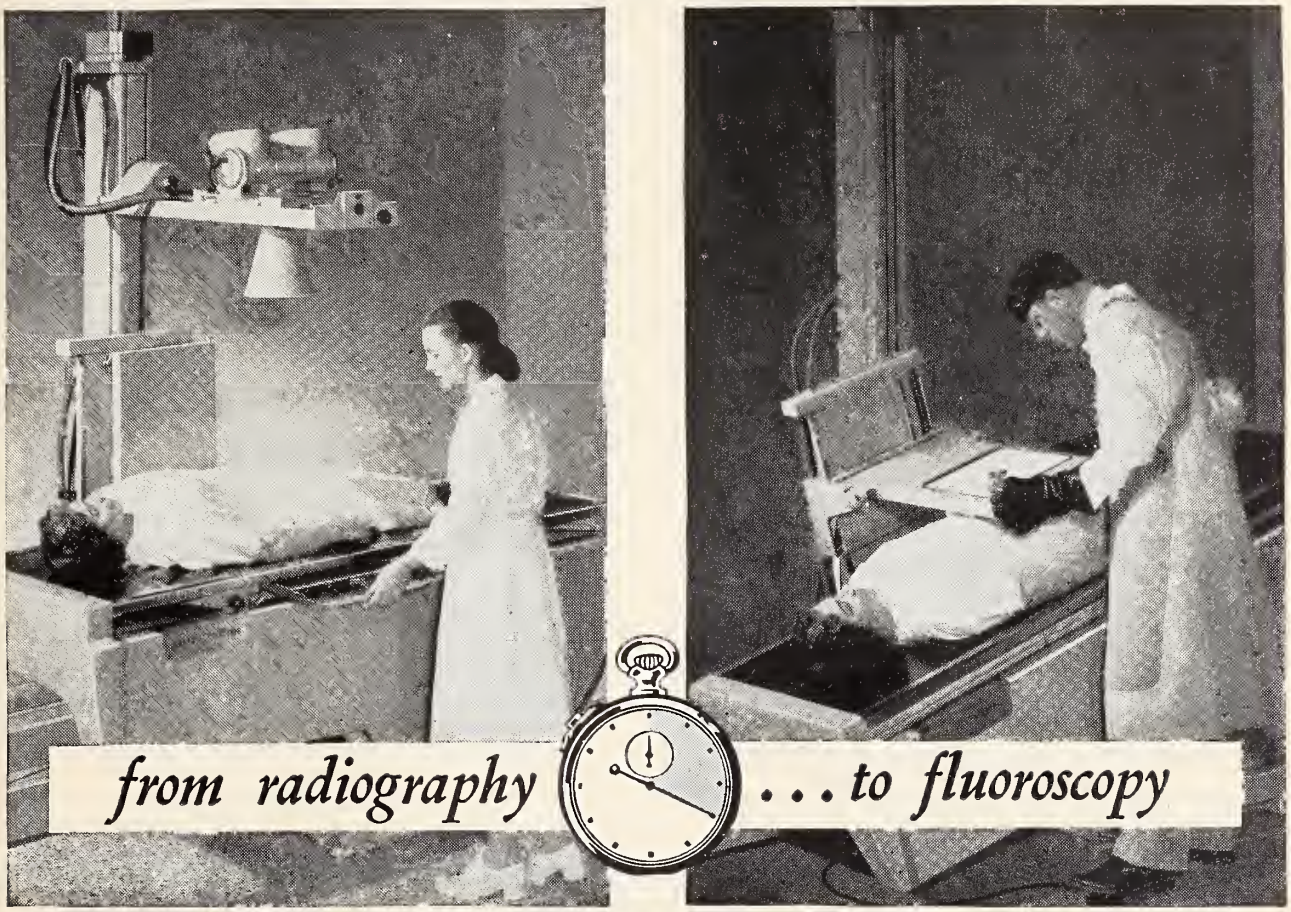

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Hospitals Join FDA and Affiliated Groups in Drug Reaction Study

PROMPT REPORTING of unusual or adverse reactions to drugs is the objective of a new joint study being carried on by eleven leading hospitals, the Food and Drug Administration announced recently.

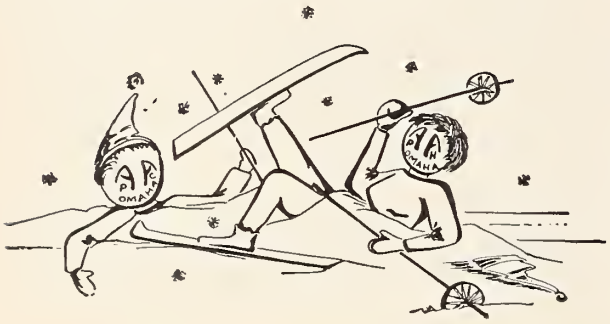
The pilot reporting system, sponsored by FDA, is being developed with the collaboration of the American Association of Medical Record Librarians, the American Society of Hospital Pharmacists, the American Medical Association, and the American Hospital Association.

Such a reporting system has been undertaken to obtain information regarding effects of drugs which may appear in some patients when they are administered to large numbers of people. This problem has been magnified by the increasing number of potent new drugs. Even the most extensive clinical studies cannot forecast all types of drug reactions which may develop throughout the population. Hospitals provide an ideal site for observing the effects of drugs and obtaining essential information which is not available from other sources.

This joint study is being undertaken in the interest of public health, better patient care, and the furtherance of the objectives of the Federal Food, Drug and Cosmetic Act to insure the safe use of drugs, FDA said.

The participating hospitals are:

George Washington University Hospital, Washington, D. C.; Grace Hospital, Detroit, Mich.; Hartford Hospital, Hartford Conn.; Oakwood Hospital, Dearborn, Mich.; Lakewood Hospital, Lakewood, Ohio; Medical College of Virginia Hospital, Richmond, Va.; St. Joseph's Hospital, Providence, R. I.; U. S. Naval Hospital, Bethesda, Md.; U. S. Public Health Service Hospital, Baltimore, Md.; Walter Reed Army Hospital, Washington, D. C.; Western Pennsylvania Hospital, Pittsburgh, Pa.



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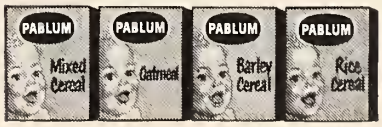

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Abstracts:

COMPARISON OF RAPID INTRAVENOUSLY AND ORALLY ADMINISTERED CONTRAST MEDIUMS FOR ROUTINE GALL-BLADDER STUDY

Kremens, V., Berger, S.M., Cohn, E.M.: New England J. Med., 254:705-706, 1956.

The authors report the x-ray examination of 68 non-jaundiced patients by the usual oral administration of dye, and a short time later with the intravenous injection of Cholografin. In case of nonvisualization following the oral dye, the examination was repeated on the following day before reported as nonvisualizing. Before the use of the intravenous dye the patient was tested with 1cc. of the solution intravenously, ten minutes after which 20cc. of the 40% solution was injected over a period of 8 to 10 minutes. Visualization was accomplished in 24 patients using the oral method; in 39 patients by the intravenous method. Twelve of the 15 patients who visualized only after intravenous dye showed non-opaque gallstones. While obviously superior, the intravenous method is not practical for routine work because of the more frequent reactions, the necessity for intravenous injection, and the much greater amount of time required of the x-ray department for completion of the study.

This report makes failure of visualization following oral dye in a non-jaundiced patient a very positive indication for restudy following the intravenous injection of the dye.

Stephen L. Johnson, M.D., Evansville.

TREATMENT OF CHRONIC GRANULOCYTIC LEUKEMIA WITH MYLERAN

Schilling, R. F., Meyer, O. O.: New England J. Med., 986-989, 1956.

Nineteen adults with chronic granulocytic leukemia were treated with Myleran. In fourteen of these, remissions lasting from one to thirty months were obtained. In one patient three separate remissions were produced. Five patients were listed as treatment failures. Four adults with acute leukemia have been treated with this drug without benefit, and these cases are not included in the report. In addition to the usual sign of remission, namely, increase in hemoglobin, decrease in total white count, and decrease in the size of the spleen, the treated patients had a definite increase in their sense of well being along with improvement in strength and decrease in sweating.

Treatment was usually started with four to six milligrams of Myleran daily. It was continued until the hemoglobin approached normal without concern for the level of the leukocyte count. If the leukocyte count dropped to 10,000 treatment was stopped. The authors believe that maintenance therapy is desirable and that not more than one or two milligrams a day is required. They are favorably impressed with the results of this drug, and they are selecting it as treatment of choice in recently diagnosed patients and those no longer controlled by radiation.

Stephen L. Johnson, M.D., Evansville.

SERUM "PROSTATIC" ACID PHOSPHATASE AND CANCER OF THE PROSTATE

Fishman, W. H., Bonner, C.D., Homburger, F.: New England J. Med., 255:925-933, 1956.

Association of an elevated serum acid phosphatase with prostatic carcinoma has been recognized for 15 years. Recently it has been found that acid phosphatase is derived from various body tissue, can be separated, and that the enzyme derived from the prostate, almost exclusively, is inhibited by L-tartrate and can be measured as an entity. Using the technique of Fishman and Lerner the authors found values for the prostatic acid phosphatase above 0.6 King-Armstrong units only in cancer of the prostate, with rare exceptions. On the other hand, many patients showing an acid phosphatase level below 5 K-A units by the standard techniques, which would be considered normal,

Please turn to page 170

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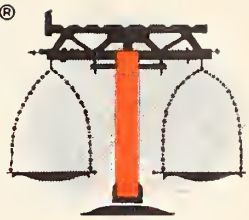

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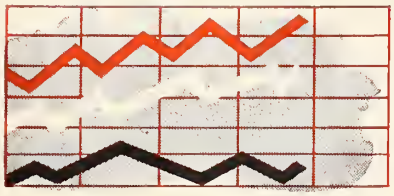

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Abstracts: (continued)

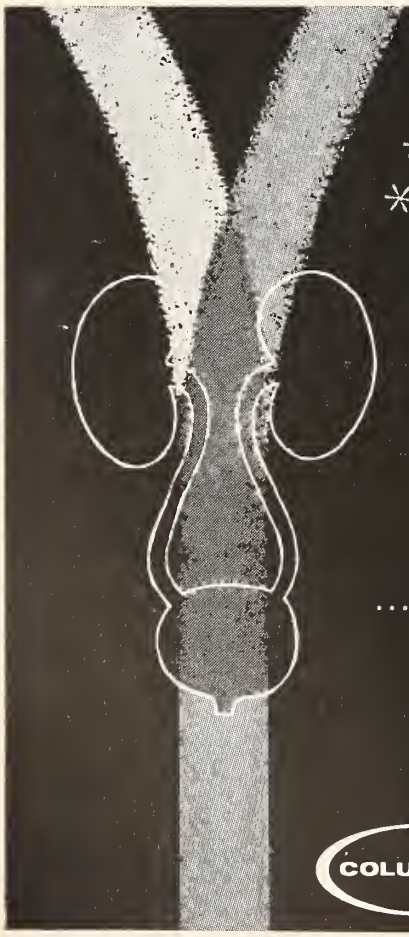
showed elevation of the prostatic acid phosphatase above the 0.6 level and associated with cancer of the prostate. This specific acid phosphatase has also been found elevated in prostatic carcinoma before even soft tissue spread seemed to be present.

The authors have found values in the blood increased following prostatic massage and administration of testosterone, and diminished during and sometimes after estrogen therapy. The most frequent cause of elevation of this enzyme in the absence of prostatic cancer was found in prostatic hypertrophy. The authors believe that this enzyme is secreted by normal prostatic tissue rather than by the tumor and that the tumor in some way facilitates the entrance of the enzyme into the blood stream.

Stephen L. Johnson, M.D., Evansville.

AMA Council on Rural Health Plans March 7-9 Meeting

"Together We Build" is the conference theme for the Twelfth National Conference on Rural Health which will be held in the Brown Hotel, Louisville, Kentucky, on March 7, 8 and 9. All physicians are invited to attend. The conference is sponsored by The Council on Rural Health of the American Medical Association.



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Subjects to be covered include bony trauma, soft tissue trauma, vascular injuries, bone grafting, traction technic, industrial casualties, farm injuries, auto crash injuries, burns, amputations, head injuries, and other conditions.

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Volume 50 — February 1957 — Number 2

Auricular Infarction

J. PAUL SHIELDS, M.D.*

Indianapolis

CLINICAL DIAGNOSIS of auricular infarction is rare and could be considered of purely "academic" interest and without any clinical significance were it not for (1) the high incidence of complicating arrhythmias, (2) frequency of auricular rupture, (3) formation of mural thrombi at site of infarction in 84% of cases with complicating pulmonary emboli in 24% of these,[1] and (4) demonstration of electrical phenomena associated with auricular depolarization and repolarization (PTa).

The electrocardiographic diagnosis of auricular infarction is based on (1) the appearance of arrhythmias and (2) changes in the electrical phenomena of auricular repolarization (PTa).

The incidence of complicating arrhythmias in auricular infarction is 74% as compared to only 9% encountered in ventricular infarction. The arrhythmias consist of auricular flutter, auricular fibrillation, auricular premature beats, various degrees of block, paroxysmal auricular tachycardia, sinus arrest, wandering pacemaker and A-V nodal rhythm. These arrhythmias may be transient or persist indefinitely. Different mechanisms may be seen in the same individual during the course of illness.[1, 5, 6, 10]

The PTa segments comparable to STT segments of ventricular activity are usually depressed in standard limb leads II and III,[1, 6, 7, 8] but in the case reported by Hellerstein[5] these were elevated. In a unique case reported by Miller and Perelman[6] the PTa segment and the T waves of the P are clearly visible.

This case demonstrates the electrical phenomena associated with auricular depolarization and repolarization in such a uniquely clear manner that after reviewing the litera-

* Krannert Fellow from the Robert M. Moore Heart Clinic, Indianapolis General Hospital.

Supported by Hermann C. Krannert Fund of the Indiana Heart Foundation and Indiana State Board of Health.

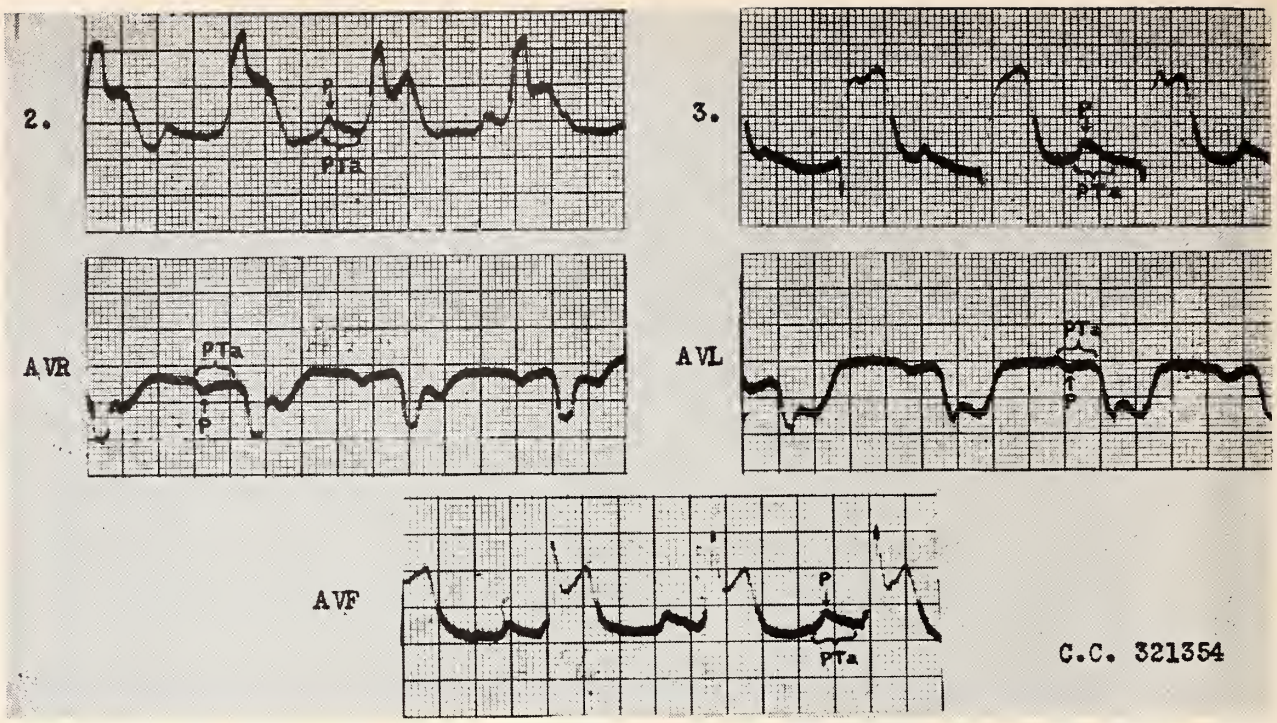

Figure 1. This EKG shows auriculo-ventricular dissociation with block. The auricular rate is about 150 and a ventricular rate about 75. The ventricular complexes show evidence of acute posterior wall injury. Inspection of P waves shows these to be sharply defined and followed by an elevated segment (PTa) in Leads II, III, AVF and depressed in AVR and AVL. These are the changes of auricular infarction.

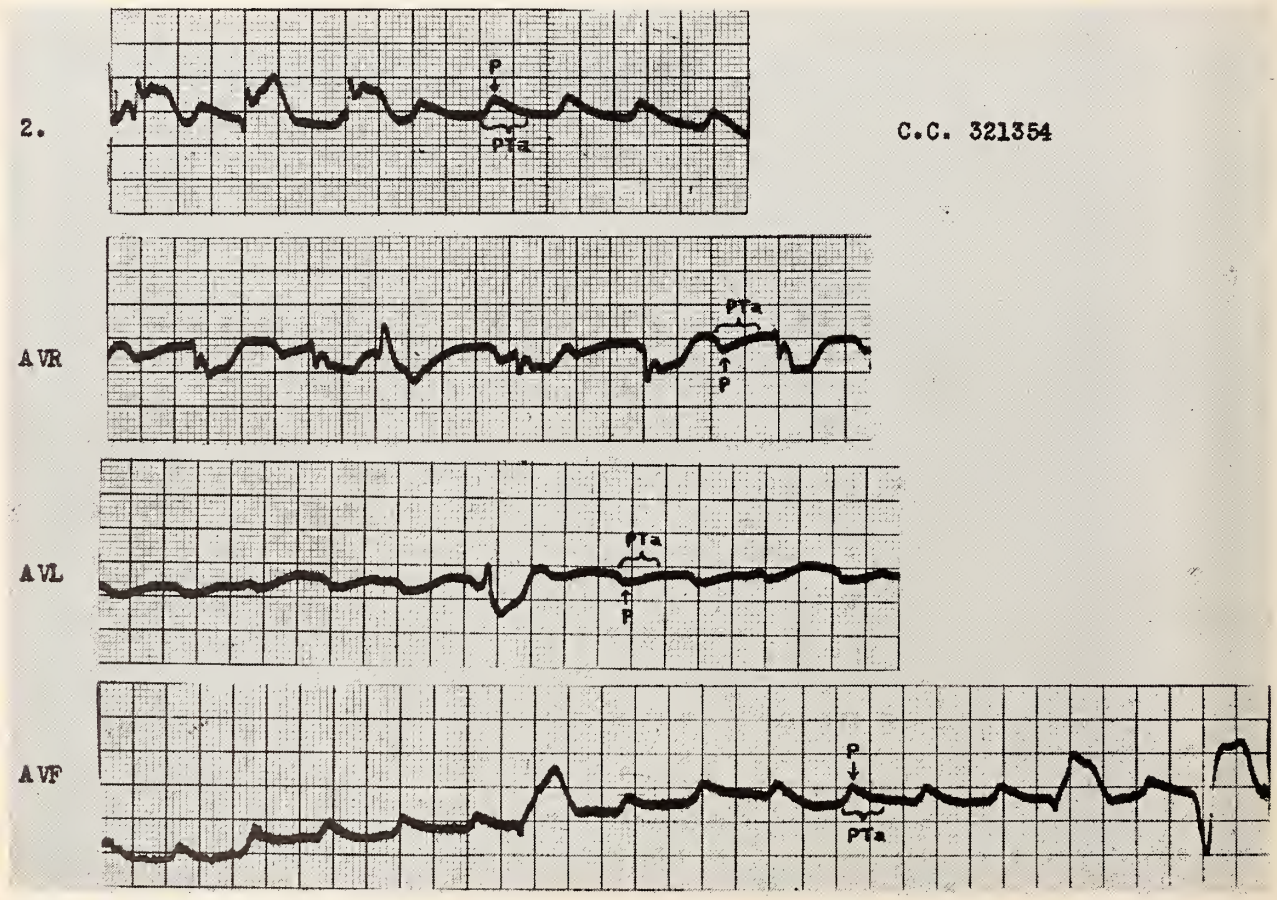

Figure 2. This tracing shows progressive signs of ventricular infarction. Q waves are not present in Leads II and AVF. The rhythm is interrupted by periods of ventricular asytole. It is during these periods that the changes indicative of auricular infarction (Fig. 1) are clearly demonstrated. The PTa measures at least 0.24 seconds.

ture on the subject the author feels the case should be reported.

CASE REPORT

The patient, a 65 year old male, was admitted to Indianapolis General Hospital on 10-31-55 with an hour history of epigastric pain, nausea, and vomiting.

Physical examination revealed a thin, colored male in shock, with Cheyne-Stokes periods and cyanosis. The neck veins were distended. Blood pressure was not obtainable, pulse 75. The chest was clear to auscultation and percussion. The heart sounds were poor in quality and at times not audible. Electrocardiograms taken at time of admission are shown in Figs. 1 and 2.

Despite supportive therapy of oxygen, morphine sulphate and norepinephrine the patient expired 1 hour after admission.

At autopsy the significant findings were confined to the heart. The organ showed no gross abnormalities on inspection. Three centimeters from the left coronary ostium there was a thrombus occluding the lumen. The right coronary artery had minimal atherosclerosis. Cross section of the myocardium demonstrated many small diffusely scattered areas of grayish discoloration. The posterior wall of the left ventricle showed evidence of fresh infarction.

Microscopic examination of the left ventricle and both atria demonstrated fading of nuclei and vacuolations within muscle fibers consistent with acute myocardial infarction.

DISCUSSION

There is no doubt that the patient had a myocardial infarction diagnosed by EKG and autopsy examination. Auricular infarction proved by necropsy was diagnosed electrocardiographically prior to patient's death. The deviation of the PTa was the diagnostic feature. The elevation in Leads II and III is in contrast to the cases reported in the literature in which the PTa in II and III was depressed. Although the changes were clear in the initial tracing (Fig. 1) they became more apparent during periods of ventricular asystole (Fig. 2). In addition to PTa changes the arrhythmia which so often complicates auricular infarction was noted in this case.

It is difficult and of no clinical significance to attempt to localize the auricular infarction on the basis of displacement of the PTa.

SUMMARY

A case of auricular infarction diagnosed antemortem and confirmed by autopsy is reported.

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Orthostatic Hypotension

ROBERT C. ZISS, M.D.

Evansville

LOW BLOOD PRESSURE, generally speaking, is not a disease in itself. Indeed, it is most frequently a manifestation of good health, especially when it occurs in the middle-aged or elderly who have no symptoms. It has been estimated that 25 per cent of the general population have systolic levels of 110 mm. of Hg or less. In these instances no other treatment than congratulations is required.[1]

Hypotension, however, can be a finding in a disease state in which symptoms will be present. For example, a patient with a systolic pressure of 100 mm. of Hg or less may complain of nervousness or fatigability. Perhaps one such patient in a thousand has Addison's disease and one in ten some organic disorder such as aortic stenosis. The remaining nine will usually show evidence of some emotional disorder in which the hypotension is merely an incidental finding. The emotional disturbance may require treatment, but not the low blood pressure.

Orthostatic, or postural, hypotension, however, is a chronic, recurring type of low blood pressure which appears to be a specific pathologic entity and one which deserves special study and recognition.

It was described for the first time in 1925 when Bradbury and Eggleston reported three cases of orthostatic hypotension which they had observed at the Bellevue Hospital.[2] Subsequent reports have neither improved greatly their original description of the entity nor profoundly added to their etiologic hypotheses.

An attempt to distinguish between idiopathic and secondary orthostatic hypotension seems to be impossible in our present state of knowledge because, as will be seen, all cases are actually cryptogenic.

SYMPTOMS AND FINDINGS

The chief complaint of the patients studied by them and further described by later observers was the occurrence of syncopal attacks after or during exertion or even after standing erect for several minutes.

The significant finding in all cases was that with a change from the recumbent to the erect posture an abrupt, dramatic fall in both the systolic and diastolic blood pressure occurred. The drop persisted as long as erect posture continued. There was usually a drop in systolic pressure of at least 50 mm. of Hg with a smaller, corresponding drop in diastolic pressure. The blood pressure and pulse readings of a typical patient may be tabulated as follows:

	Systolic Pressure	Diastolic Pressure	Pulse
Head down 45°	135	90	80
Recumbent	118	82	76
Head up 45°	92	70	76
Head up 90°	64	50	84
Head up 90° for 4 minutes	44	24	84

In addition to the hypotension, other features of the disorder are a slow, unchanging pulse rate, vertigo and weakness, a lessened capacity to sweat, impotence, and bladder dysfunction. Young[3] has added to this list such inconstant findings as greater urinary frequency at night, a low basal metabolic rate, a blood urea nitrogen of 40 or more, pallor, secondary anemia, and a false appearance of youth. In a large percentage of reported cases nervous system changes have also been noted, including neurosyphilis, demyelinating diseases of the central nervous system, and diabetic neuropathy.

Bradbury and Eggleston observed that the ability of the vagus to respond to pronounced

elevation of blood pressure (e.g., by injection of epinephrine) did not occur. Similarly they found that the inability to sweat was not due to a defect in the sweat glands because these did respond to the pharmacological stimulation of pilocarpine. They believed that paralysis of the sympathetic vasoconstrictor endings best explained the blood pressure reactions; this, they felt, explained the total absence of the normal vasomotor control by which blood pressure is maintained at constant levels in normal individuals despite postural changes.[2]

Among the infrequent case reports of the disorder which have appeared in the past 32 years was the paper of Spingarn and Hitzig[4] who in 1942 collected and analyzed 50 adequately studied cases. The only constant finding in all reports was the immediate fall in blood pressure on standing. The systolic drop was at least 50 mm. of Hg in two-thirds of the cases and somewhat less in the rest. Fainting and dizziness with standing were common, but many patients had been observed to be asymptomatic with great fluctuations in pressure while others tolerated poorly even minimal blood pressure changes. In 50 per cent no or little acceleration of pulse was noted with standing; in the other 50 per cent the acceleration was normal or excessive. Hypofunction of sweat glands was present in only one-third of the cases. Seventy-five per cent were males and one-half were 50 years old or older. In 25 per cent central nervous system disease was noted. In the remaining 75 per cent the syndrome was regarded as an abnormality of the sympathetic nervous system in which a failure of reflex vasoconstriction accompanied change to an erect posture.

ETIOLOGY

In the years immediately following the initial description of orthostatic hypotension little progress was made in attempts to investigate the physiologic defect(s) responsible for the disease. Few subjects were available for study, but had they been, what experiments were available to explain the nature of the disorder? The original supposition of Bradbury and Eggleston that paralysis of sympathetic vasoconstrictor endings was the only adequate explanation was applicable only as an observation.

Ghrist and Brown's report of 1928,[5] the second in the literature, advanced the theory that the major disturbance was a lack of resistance in the splanchnic vessels to the shift in blood mass occurring with the assumption of erect posture. They felt that this was associated with absent or diminished vagus regulation of the heart rate with changes in blood pressure. They concluded that the disorder was a disease of the sympathetic and parasympathetic nervous system of unknown origin.

In four of the six cases reported by Ellis and Haynes in 1936[6] there was proved central nervous system disease (two tabes dorsalis, one syringomyelia, and one hematomyelia). They naturally concluded that a central nervous system lesion must be responsible for at least some of the cases of orthostatic hypotension. From the generalized nature of the vasopressor response they felt that the theoretical lesion must be in the brain, probably in the hypothalamus.

Spingarn and Hitzig felt that the vascular reaction of orthostatic hypotension is one "which would be expected if the whole peripheral vascular bed were always wide open, inelastic, and capable of accommodating the major portion of the blood volume of the body."[4]

In summary of these earlier concepts, it was believed that the symptoms of orthostatic hypotension could be explained on the basis of the failure of efficient constriction of arterioles when the patients stand, which, it was assumed, was due to a defect in the autonomic nervous system.

A new etiologic concept was introduced by MacLean and Allen in 1940[7] when they suggested that the defect responsible for orthostatic hypotension was a failure of the mechanism providing for adequate return of venous blood to the heart. In a series of experiments they attempted to demonstrate that fainting in orthostatic hypotension was the result of pooling of blood in the dependent portions of the body due to a loss of venous tone. This results in a reduced return

of venous blood to the heart with consequent decreased cardiac output and lowered arterial blood pressure.

Stead and Ebert,[8] on the other hand, conducting an intensive study of three hypotensive patients in 1941, reported normal amounts of pooling of blood in the leg and splanchnic veins of the subjects. This suggested to them that the disorder could best be explained by an abnormal response to normal pooling, the reason for the abnormal response being a lesion in the sympathetic nervous system centers.

In 1950 Hickam and Pryor,[9] using the Fick principle to determine cardiac outputs following cardiac catheterization in orthostatic hypotensive patients, demonstrated a decrease in cardiac output when the subjects were moved to an upright position on a tilt table. After the administration of intravenous albumen the decrease with tilting was much smaller. The larger output falls suggested to them an inadequate venous return to the heart in orthostatic hypotension due to uncompensated dilatation of the venous system under pressure. They concluded that the normal reflex response to assuming the erect posture, an increase in venous tone, which is necessary for maintaining a normal cardiac output, simply does not occur in orthostatic hypotension.

Still more recent investigators regard a lack of reflex venous constriction as the crucial physiologic defect. Page *et al.*[10] cite experiments in which the Valsalva maneuver and tilting produce constriction of the peripheral venous system resulting in a shift of blood to the larger central veins in normal subjects. Similar stimuli in orthostatic hypotensive patients fail to produce an increase in central venous pressure.

Judson,[11] citing that a significant number of patients with diabetic neuropathy, tabes dorsalis, subacute combined sclerosis, and disseminated sclerosis have orthostatic hypotension, concludes that the lack of reflex changes in the circulatory system is a response to a disease of the autonomic nervous system, a disease which Weil[12] suspects is in the hypothalamus.

TREATMENT

As one might expect from the unsure etiology of the disorder, specific therapy is unknown. Bradbury and Eggleston initially proposed the application of leg and abdominal binders in 1925.[2] Ghrist first suggested ephedrine in 1928.[5] Combinations and modifications of these two seemingly rational approaches to therapy have been the basis of treatment ever since.

A schedule using 100 mgm. of ephedrine sulfate at 6 a.m. (before rising) with 50 mgm. at 10, 4, and 7 has been recommended. The use of this agent or its analogues in doses varied to the patient's response is probably indicated as a trial in most patients. The associated decrease in sweating may be treated with pilocarpine hydrochloride (gr. 1/5 t.i.d.). These drugs give only symptomatic and usually only temporary relief.

When there is associated diabetes mellitus, strict chemical control of this disorder may in time improve the hypotension.

Striking therapeutic results have been reported with the head-up bed.[13, 14] Its use resulted from the observation that orthostatic hypotensive patients often improved greatly during the daytime, but that they were worse again the next morning after being recumbent all night. This implied that the patients lost some of their ability to adapt themselves as a result of lying flat. When the head of the bed was elevated 12 to 16 inches an improvement was observed which was maintained. Rest on an ordinary flat bed for one or several nights resulted in a reversal of the patient's condition; this could be reversed again with reinstitution of the head-up bed.

Most recently it has been suggested that improvement may be expected with counterpressure garments similar to the so-called gravity suits developed for high altitude flying.[15] Air-filled garments which apply counter pressure from the waist down were effective in 6 of 10 patients with severe orthostatic hypotension treated by Sieker *et al.* at Duke University. These suits are specially designed and made by the David Clark Co., Inc., of Worcester, Massachusetts.

SUMMARY

Orthostatic hypotension, a subject deserving more recognition than it now receives,

has been reviewed. Special emphasis has been placed on the development of the physiologic hypotheses proposed to explain the etiology of the disorder which have been advanced since 1925 when the entity was first described.

Possible methods of management have been suggested including vasopressor drugs, leg and abdominal binders, the head-up bed, and counterpressure garments.

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Diagnosis of Ventricular Tachycardia

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OF ALL MEDICAL EMERGENCIES, few require more prompt diagnosis and treatment than does ventricular tachycardia. Ironically, of all the cardiac arrhythmias, ventricular tachycardia is probably the most difficult to diagnose.

The clinical findings suggestive of ventricular tachycardia are well documented.[1,2,3,4] These include rapid, slightly irregular rhythm, changing intensity of first heart sound, and failure to affect the arrhythmia by vagal stimulation. The diagnosis is more tenable if these signs are associated with severe heart disease, evidence of digitalis intoxication, or appearance of premature beats shortly before the onset of ventricular tachycardia. Final diagnosis, however, must depend on electrocardiographic confirmation.

Accepted electrocardiographic criteria[5,6,7,8,9,10] include: (1) regular, or slightly irregular rate varying from 100 to 180, rarely exceeding 200 per minute, (2) prolonged (aberrant) ventricular (QRS) complexes, and (3) an independent sinus rhythm (P waves can sometimes be identified). Isolated ventricular prematures antedating the arrhythmia but resembling ventricular complexes during the paroxysm and the presence of a compensatory pause after the tachycardia is terminated, add support to the diagnosis.

The above criteria if satisfied are probably sufficient for the diagnosis of the average case of ventricular tachycardia especially if treatment alone is of prime importance. However, for the purposes of study of the natural history of this arrhythmia, its prognosis, incidence of associated heart disease, response to various drugs, these criteria alone leave something to be desired. The difficulties attending the recognition of ventricular tachycardia are familiar to all attempting to make the diagnosis.

Criteria which are usually accepted as diagnostic of ventricular tachycardia include (1) "capture" beats with normal QRS (2) fusion (combination) beats.[9,11,12,13]

In the emergency room and the wards of the Indianapolis General Hospital, where numerous arrhythmias are encountered, a frequent problem has been the differentiation of supraventricular from ventricular tachycardias. Many tachycardias with some of the traditional criteria indicating ventricular origin did not stand close scrutiny and were ultimately demonstrated to be supraventricular in origin.

It is the purpose of this paper to: (1) relate our experience with this problem, (2) point out the pitfalls of the various "diagnostic" criteria of ventricular tachycardia, (3) show examples of unequivocal ventricular tachycardia, (4) present some interesting cases posing a problem of differential diagnosis.

DESCRIPTION OF THE ELECTROCARDIOGRAMS

Fig. 1. The patient, a 54 year old male, was admitted to Indianapolis General Hospital for the treatment of a cardiac arrhythmia. It was

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From the Robert M. Moore Heart Clinic, Indianapolis General Hospital.

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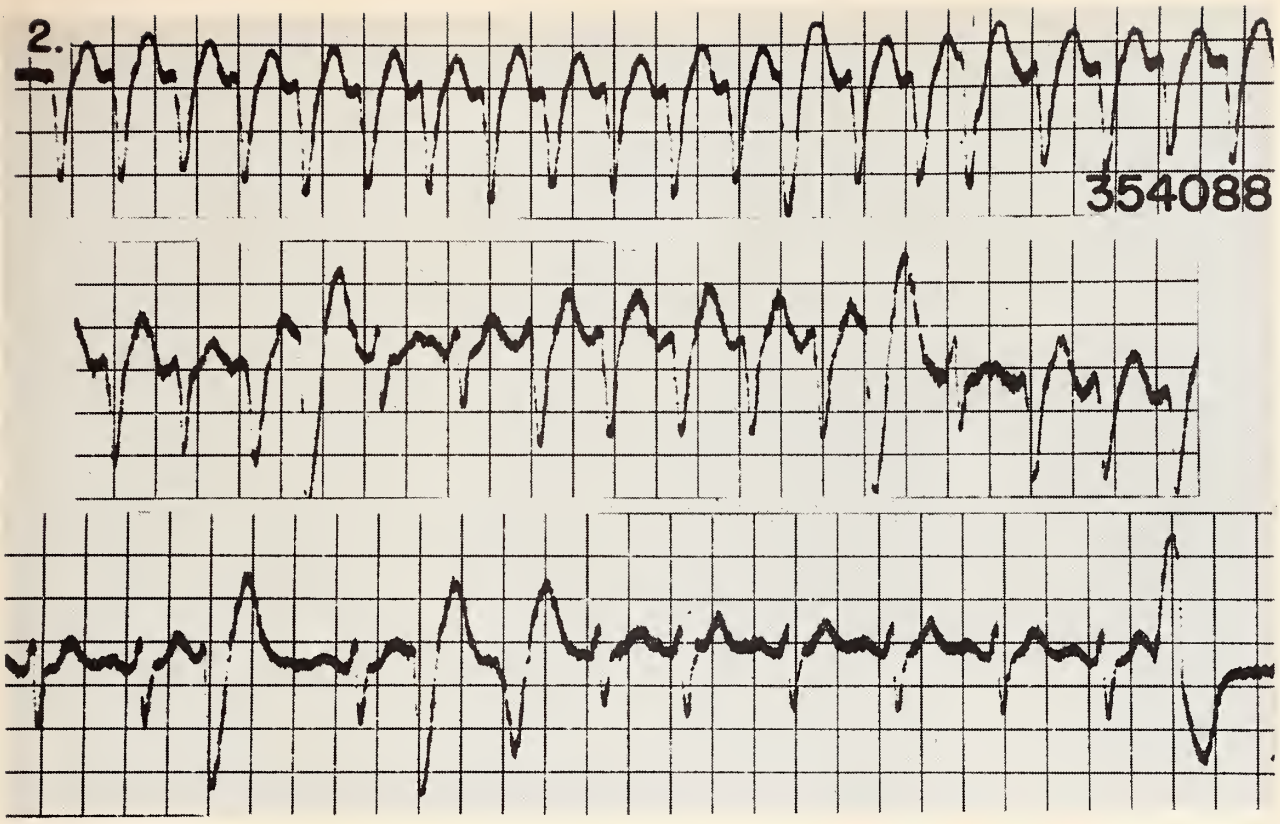


Figure 1. Description in text.

assumed that since the diagnosis on previous admission was unequivocally established as ventricular tachycardia (Fig. 8) the problem was the same this time. He was given pronestyl intravenously and the following electrocardiograms were obtained.

For purposes of clarity of presentation, the bottom strip will be described first. It represents a tracing, obtained after treatment, and shows sinus tachycardia with multifocal ventricular premature beats. The QRS of sinus beats measure .12 sec., indicating a basic intraventricular conduction defect or delay due to pronestyl.

The upper strip was obtained before treatment. The rate is 200 and perfectly regular. The QRS complexes are aberrant. This tracing is entirely compatible with ventricular tachycardia, especially in view of past history. Careful observation, however, discloses that complexes 13 and 16 occur earlier and differ some from the remainder of the QRS complexes. These are no doubt ventricular premature beats having identical appearance to those recorded in the bottom strip. Although secondary ventricular ectopic beats have been described in ventricular tachycardia, their rarity should suggest that the mechanism observed here may not be ventricular tachycardia.

The diagnosis becomes obvious in the middle strip. The first three complexes are aberrant and fairly evenly spaced. The fourth complex is premature and different in appearance. It represents a ventricular premature with a short compensatory pause. The next two beats are sinus in origin with an R-R of .40 sec. The T following the second sinus beat is taller and represents a buried P wave with an R-R of .34. The subsequent five beats are perfectly regular and faster than the two sinus beats. The first of this run has an initial R wave similar to the "normal" beat. As the rate becomes faster, the R is lower and the complex becomes more aberrant. A similar cycle repeats itself with the appearance of the next ventricular premature beat (complex 12).

The final diagnosis is auricular tachycardia with aberrant conduction. The slowing from upper to middle strip was due to pronestyl. The diagnosis becomes clear because after the compensatory pause of the ventricular premature, the sinus rhythm takes over and reveals the onset of tachycardia with a premature P and gradual aberration of QRS complex. The gradual aberration indicates supraventricular origin of the tachycardia. The patient subsequently de-

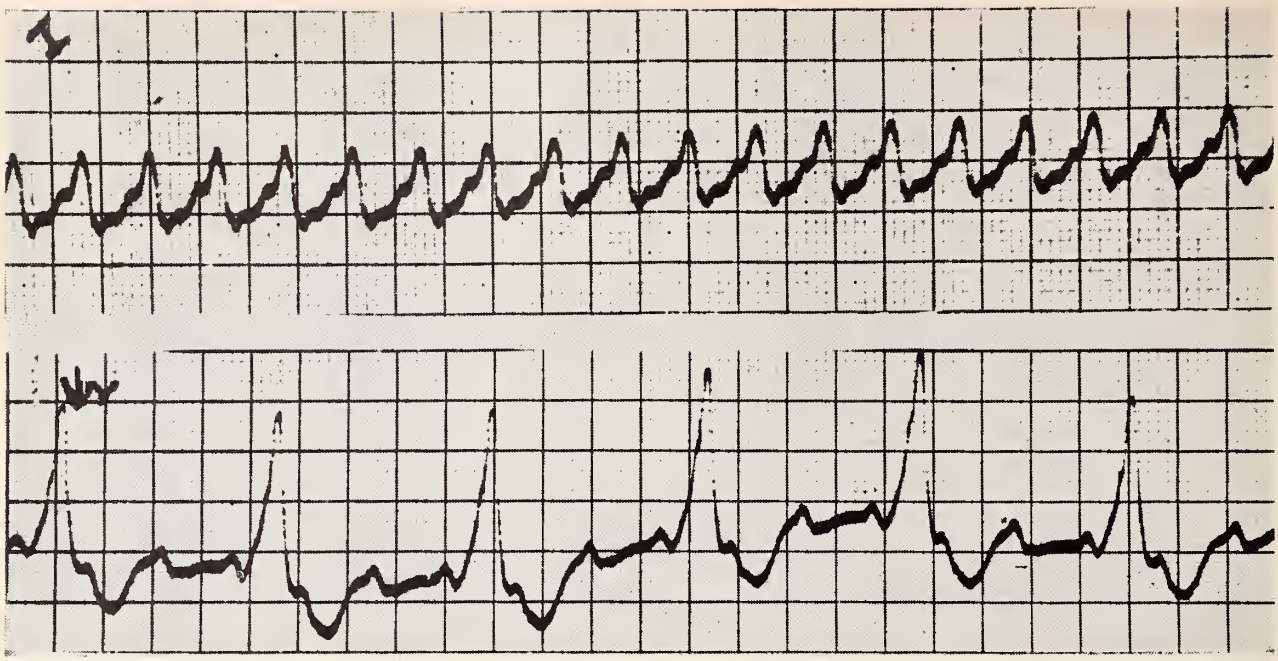


Figure 2. Description in text.

veloped unequivocal ventricular tachycardia (Fig. 9).

Fig. 2. The patient was 74 years old when seen. He had a rapid heart rate for 72 hours prior to admission. Physical examination disclosed the individual to be in acute distress with all the classical symptoms of shock. The electrocardiogram was interpreted as indicating ventricular tachycardia. He was treated with quinidine intravenously with improvement in his condition.

Upper strip (Standard lead I) shows a regular rate of 220 per minute. The QRS complexes are widely spread. There are three findings which should make one question the diagnosis of ventricular tachycardia. These are (1) regularity, (2) rapidity of the heart and (3) RBBB pattern of QRS complexes. It is unusual for a ventricular tachycardia to exceed 200 beats per minute and more often than not, RBBB pattern is associated with supraventricular conduction.

Lower strip (lead VI) shows upright P waves with a rate of 205 and a 3:1 ventricular response. The QRS complexes are aberrant and represent right bundle branch block.

The diagnosis in this case is auricular tachycardia (or extremely slow flutter) in the presence of right bundle branch block simulating ventricular tachycardia.

Fig. 3. This patient was admitted to Indianapolis General Hospital for the treatment of arteriosclerotic heart disease with congestive heart failure. The treatment consisted of digitalis, low sodium diet and mercurial diuretics. Tracings A and B were obtained on different days.

A. The rhythm is auricular fibrillation. The first three ventricular complexes in lead III, and third and fourth complex in AVL, are prolonged. The rate of these complexes is faster than of the normal ones. In addition, there is a gradual prolongation of the QRS in AVL. The second complex is somewhat more aberrant than the first but not as aberrant as the third or fourth. There is no compensatory pause after the prolonged complexes disappear.

B. The ventricular complexes are aberrant and identical to the few observed in A. In V_2 and V_6 following beats 3 and 2 respectively, the pause is prolonged and the ventricular complexes which follow are narrow (not aberrant).

The diagnosis in B is not ventricular tachycardia but auricular fibrillation with aberrant conduction through the ventricles because of delay in the right bundle branch.[14] This delay is due to inability of the bundle to conduct after a certain rapid rate of stimulation is

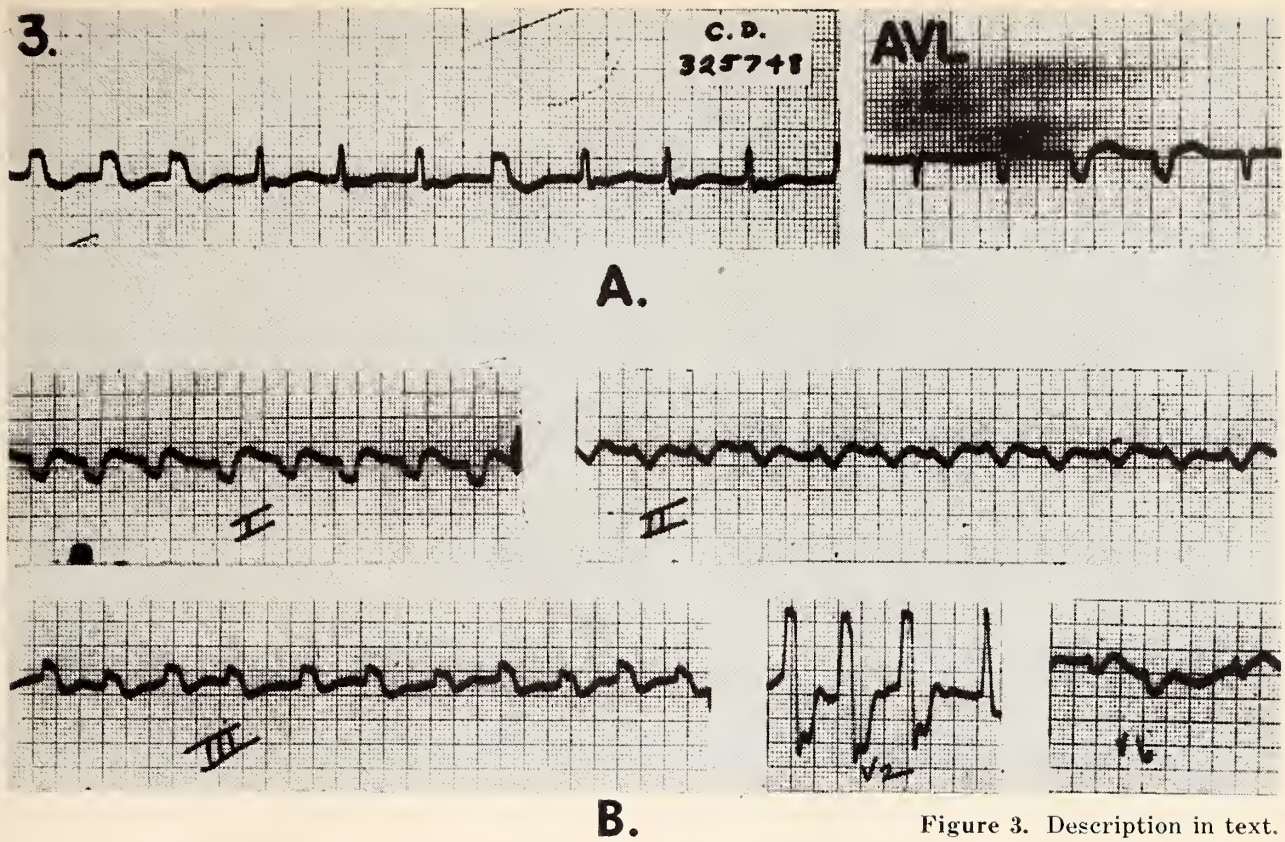


Figure 3. Description in text.

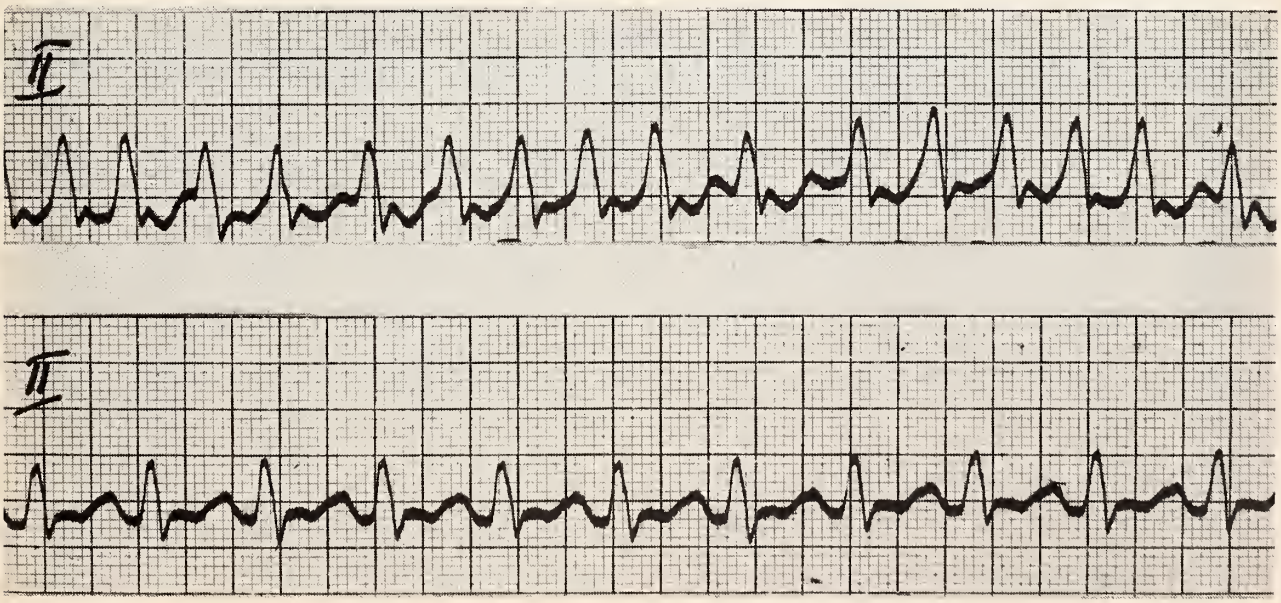
attained (critical conduction). As soon as the rate slows, there is sufficient time for the bundle to recover and the conduction returns to normal with resultant narrow QRS. Gradual aberration in A speaks against ventricular arrhythmia.

Fig. 4. The upper strip shows an irregular rhythm with a rate of about 180 beats per minute. The QRS complexes are prolonged, measuring .16 sec. Some approximation of QT interval can be made after beats 5, 10, 11 and 16. It is obviously prolonged. The late appearing T waves were mistaken for independent P waves and a diagnosis of ventricular tachycardia was made.

Lower tracing shows a sinus rhythm. The QRS is similar to the one described above. QT is prolonged and P wave fused with the T wave.

Since the QRS of the sinus rhythm and

Figure 4. Description in text.



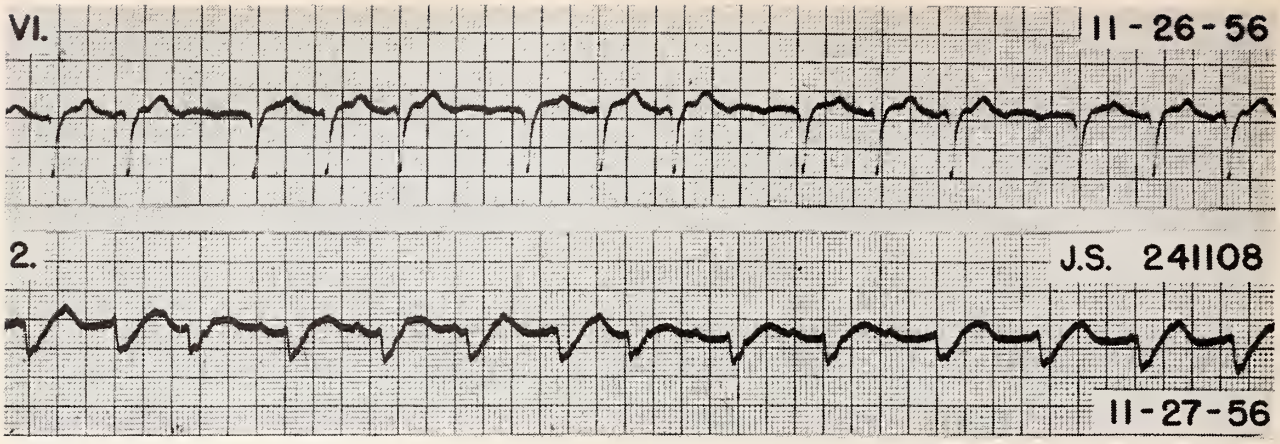


Figure 5. Description in text.

those during arrhythmia are identical, the diagnosis is supraventricular tachycardia; in this case auricular fibrillation with pre-existing bundle branch block.

Fig. 5. The patient was a 45 year old male who was admitted to Indianapolis General Hospital because of an auricular fibrillation. Digitalis was used to slow the rate and an attempt at conversion to sinus rhythm was made using quinidine.

Upper strip shows control tracing. The rhythm is one of auricular flutter with a varying 2:1 and 3:1 block. The QRS measures .12 sec., indicating intraventricular conduction defect.

Lower strip was obtained during quinidine therapy. A diagnosis of ventricular tachycardia was made on basis: (1) the QRS complexes are aberrant, (2) the rhythm is slightly irregular and (3) independent auricular (P waves) mechanism is easily identified. Careful analysis of the tracing, however, discloses at least two beats conducted from the auricules (captures) (beats 3 and 8). These are preceded by P waves and occur earlier than expected. The QRS of these supraventricular beats is aberrant, indicating delay in bundle branch (probably right). The remainder of the complexes have the same appearance as the two supraventricular beats, which indicates all the beats originate above the bifurcation of bundle of His and not in the ventricles. The diagnosis is A-V dissociation with nodal rhythm with aberrant conduction and not ventricular tachycardia. Further analysis of this tracing is not pertinent to our discussion.

This unique tracing satisfies all the classical criteria necessary for the diagnosis of ventricular tachycardia, yet it is not ventricular tachycardia but A-V dissociation with aberrant conduction due to quinidine. It is obvious that treatment with pronestyl or quinidine for supposed ventricular tachycardia would have been disastrous.

Fig. 6. These tracings are parts of numerous electrocardiograms obtained on a patient who was studied extensively because of Wolff-Parkinson-White syndrome associated with severe heart disease.

A. Upper strip (lead V5) shows a repetitive tachycardia, which is regular with a rate of 150 per minute. The pause between the runs equals two complete cycles of the tachycardia. First QRS following the pause shows a slurring upstroke (the delta wave of W-P-W) and a narrow terminal portion (conduction through the normal path—AV node, bundle of His, both bundles and the Purkinje system). As the rate speeds up, the QRS becomes more aberrant and the delta wave more pronounced, accounting for most of the QRS complex. This change shows clearly that the aberrant pathway (bundle of Kent) has a shorter refractory period than conduction through the AV node and consequently most of the ventricle is activated through the aberrant path.

Lead VI, in part A, represents the same mechanism which this time is not repetitive. This EKG could easily be interpreted as ventricular tachycardia. The knowledge that this patient has W-P-W and the repetitive nature of the arrhythmia in the upper strip indicates a supraventricular rhythm, in this instance paroxysmal auricular tachycardia in

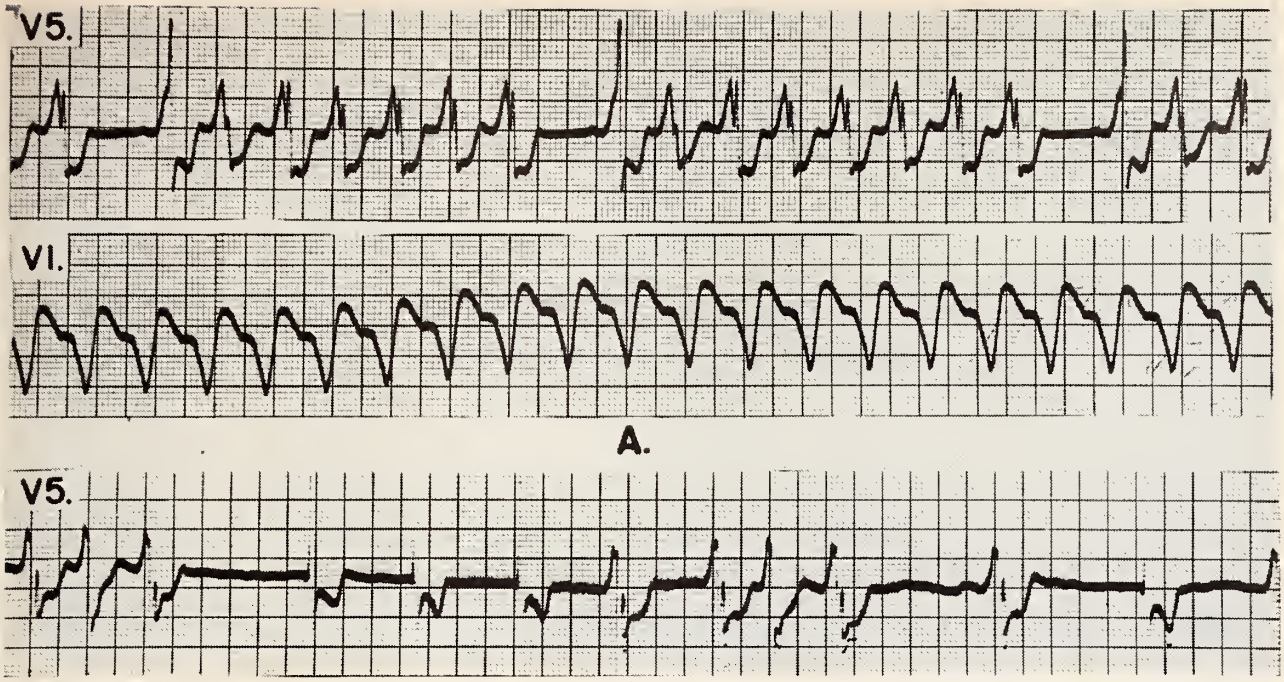


Figure 6. Description in text.

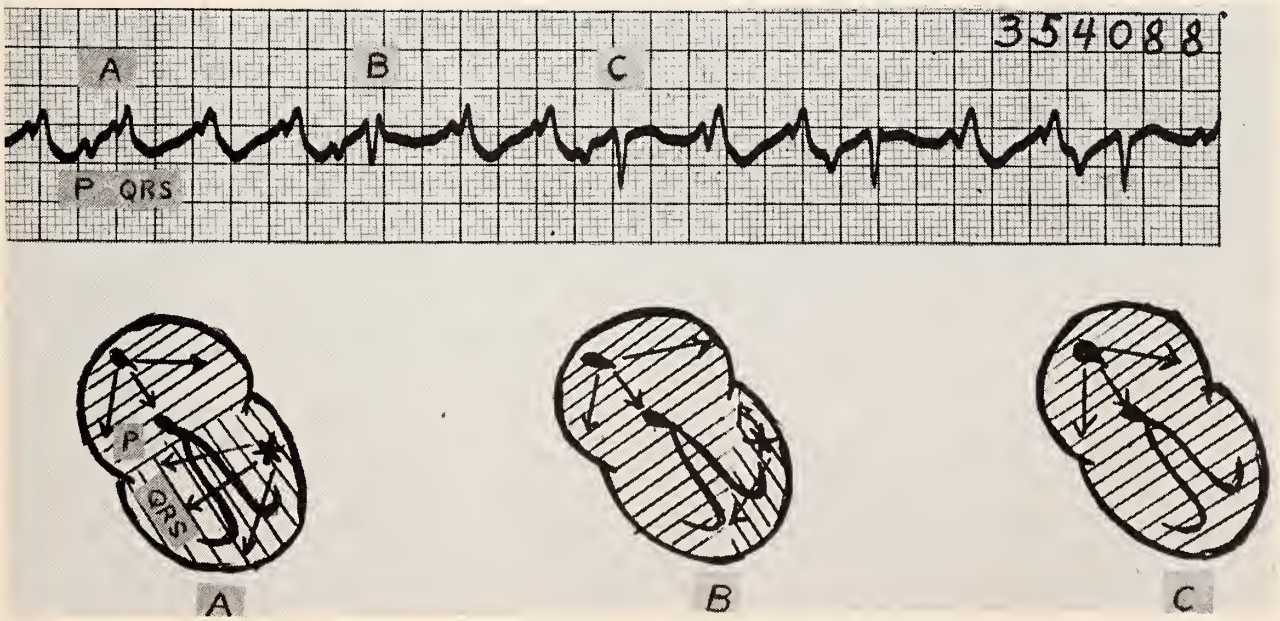
presence of Wolff-Parkinson-White syndrome.

B. Beats 1, 2, 3, 7, 8, 9, 10 and 11 are aberrant and identical with those of lead V5 in part A. Long runs of such beats were noted in other cardiograms and were thought by those not familiar with the basic diagnosis as typical of ventricular tachycardia. It is obvious, however, from previous discussion that these beats are W-P-W complexes and that the underlying rhythm is auricular fibrillation. (This strip shows normal conduction after prolonged pauses and again reflects the difference in refractory period of the aberrant and normal paths in W-P-W, provided one accepts the aberrant conduction concept of W-P-W. The various unique aspects of W-P-W observed in this patient are a subject of a separate report).

Fig. 7. This figure represents the manner of activation of auricles and ventricles in ventricular tachycardia.

Combination A of the EKG (represented in diagram A) discloses auriculo-ventricular

Figure 7. Description in text.



dissocation. The SA node ativates the auricles in a normal fashion (P wave). The ventricles on the other hand are stimulated by an ectopic ventricular focus giving rise to aberrant-looking QRS.

Combination C (represented in diagram C) reveals that the SA node stimulates both the auricles (P wave) as well as the ventricles (QRS). As a result, both complexes are normal in contour and duration. This phenomenon is described as "capture". Appearance of such complexes rules out the possibility of aberrancy due to bundle branch block. Furthermore, the fact that these captures appear after an RR which is shorter than the usual RR, speaks against aberrancy due to fatigue of conduction tissue. The latter would disappear only after a prolonged period of rest (longer RR).

Combination B (represented in diagram B) reveals normal auricular activation (P wave), but the QRS and the T wave appear to be transitory between complex A and C (fusion or combination beat). Such transitory complexes indicate that the ventricles are activated by two pacemakers (in this instance, SA node and ectopic ventricular focus) thus proving the existence of ventricular tachycardia.

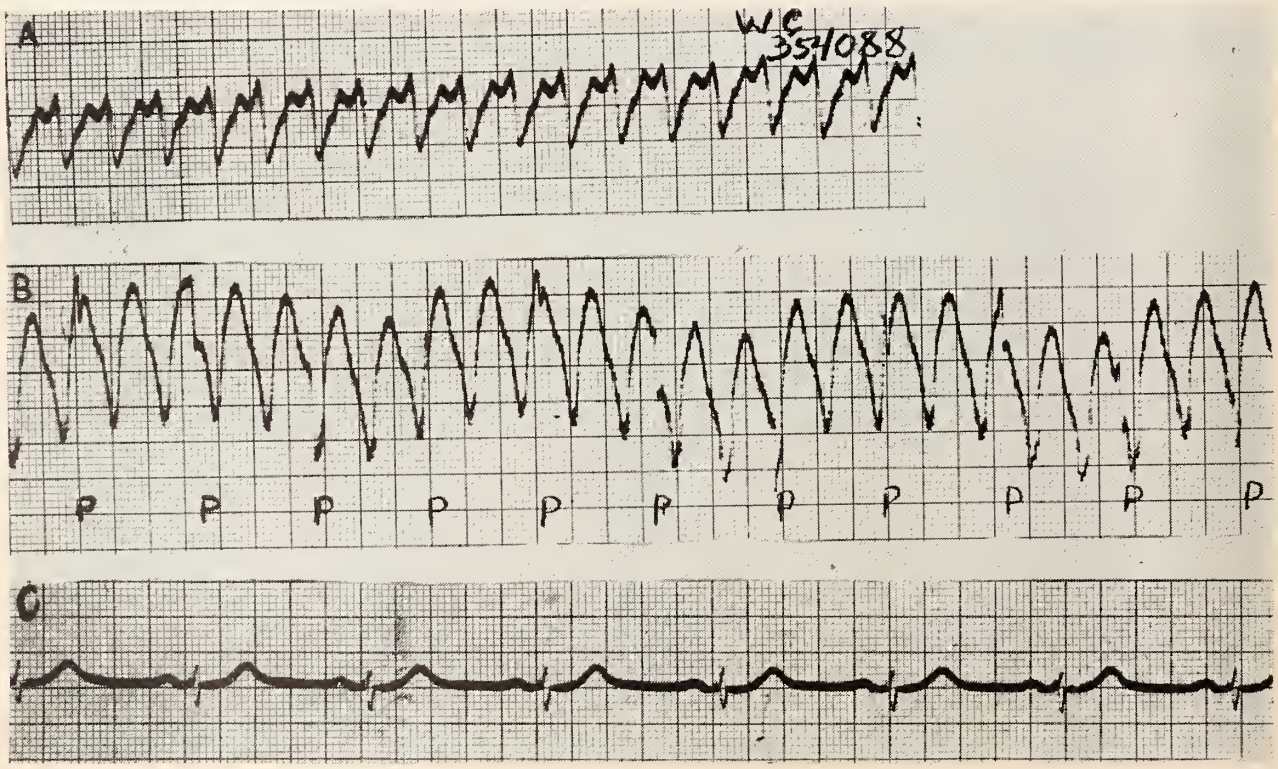
Fig. 8. These tracings were obtained at the time of first admission to the hospital. Electrocardiograms recorded on the second admission are shown in Fig. 1 and Fig. 9.

Part A shows a rate of 212 which is perfectly regular. The QRS complexes are prolonged and do not differ significantly from those recorded in Figs. 1, 2 and 5 in which the diagnosis was supraventricular tachycardia. It was assumed that because of (1) regularity and (2) rapidity, this probably represented supraventricular tachycardia (see discussion in Fig. 2). The patient was given digitalis without benefit.

An esophageal lead (part B) shows the typical narrow biphasic P waves obtained at midauricular level. The P waves had an independent rate of 90 per minute. The diagnosis of ventricular tachycardia was established. Quinidine coverted the rhythm to sinus (part C).

This unique tracing presented all the arguments against ventricular tachycardia, yet the esophageal lead proved the latter. Continued administration of digitalis under erroneous diagnosis could have proved fatal.

Figure 8. Description in text.



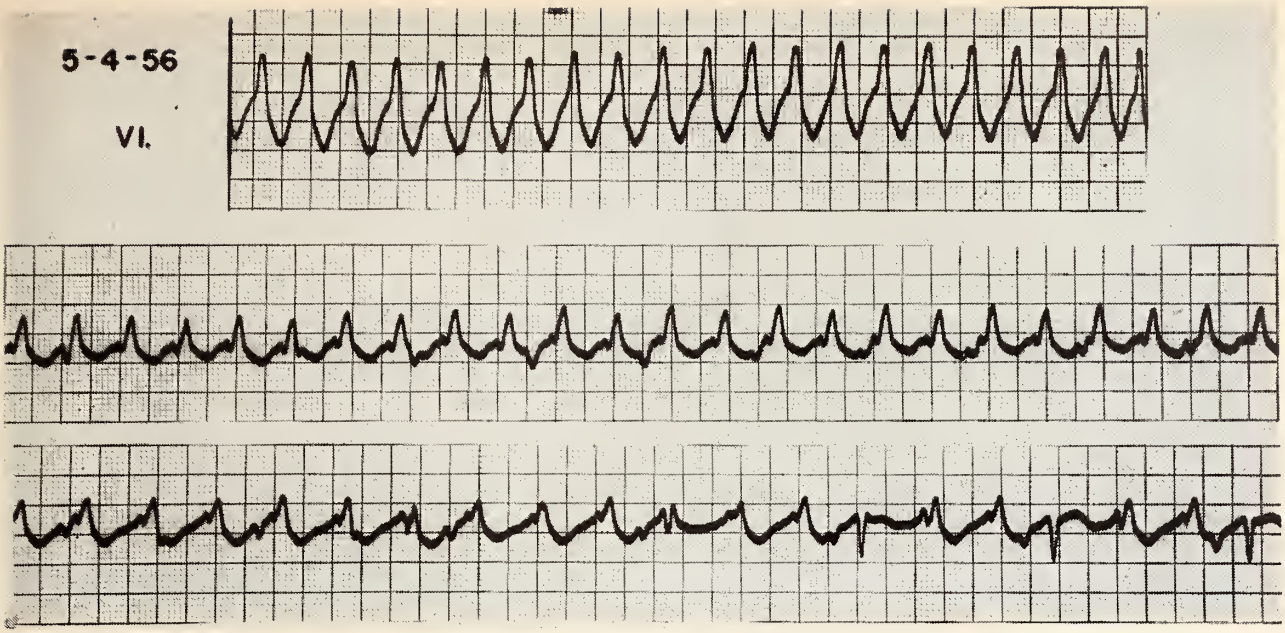


Figure 9. Description in text.

Fig. 9. This figure is the third of a series of cardiograms obtained on the same individual. Fig. 8 represents the ventricular tachycardia on initial admission. Fig. 1 represents auricular tachycardia observed on first day and Fig. 9 ventricular tachycardia occurring on the second day of his latest hospitalization respectively. The tracings reproduced in this figure are representative of the cardiograms obtained during treatment with quinidine.

Upper strip (all tracings represent lead VI) shows aberrant QRS complexes with a regular rate of 200 per minute. The contour is that of right bundle branch block. Independent sinus rhythm cannot be recognized. On basis of this tracing alone, especially in view of (1) rate of 200, (2) appearance similar to RBBB, (3) failure to identify P wave, a definite diagnosis of ventricular tachycardia is impossible.

Second strip shows significant slowing (rate 160) as a result of quinidine therapy and consequently P waves are easily identified (rate 65). Although the diagnosis of ventricular tachycardia is very likely, it is impossible to rule out A-V dissociation with nodal rhythm in presence of aberrant conduction (see Fig. 5).

Third strip shows further slowing with appearance of diagnostic features of ventricular tachycardia. These are: (1) fusion beats (complex 10), and (2) captures (complexes 13, 16 and 19). (For their significance see discussion in Fig. 7.)

Fig. 10. This patient was admitted to the Methodist Hospital on the service of Dr. Robert Palmer with one of us (C. F.) as the sponsor. History revealed myocardial infarction approximately one year prior to admission.

The upper strip was obtained on admission. Rate is 160. The QRS complexes are aberrant. An independent sinus rhythm (P waves) with a rate of 100 can be identified.

Significant slowing was observed after administration of quinidine. Beats 3, 10, 13, 17 in middle tracing and beats 4 and 8 in bottom strip are classical capture beats with normal supraventricular conduction. Beat 7 in middle strip is an example of a fusion (combination) beat. (For their significance see discussion in Fig. 7.)

DISCUSSION

Our continually increasing awareness of the difficulties attending the diagnosis of ventricular tachycardia forced us to a rather paradoxical conclusion. Namely, that the ease of diagnosis varies inversely with experience. That this is true is obvious from the study of the material presented in this paper. As long as one is not aware that a rapid, aberrant rate is more often not ventricular tachycardia, one does not find himself in a therapeutic dilemma. The patient is usually treat-

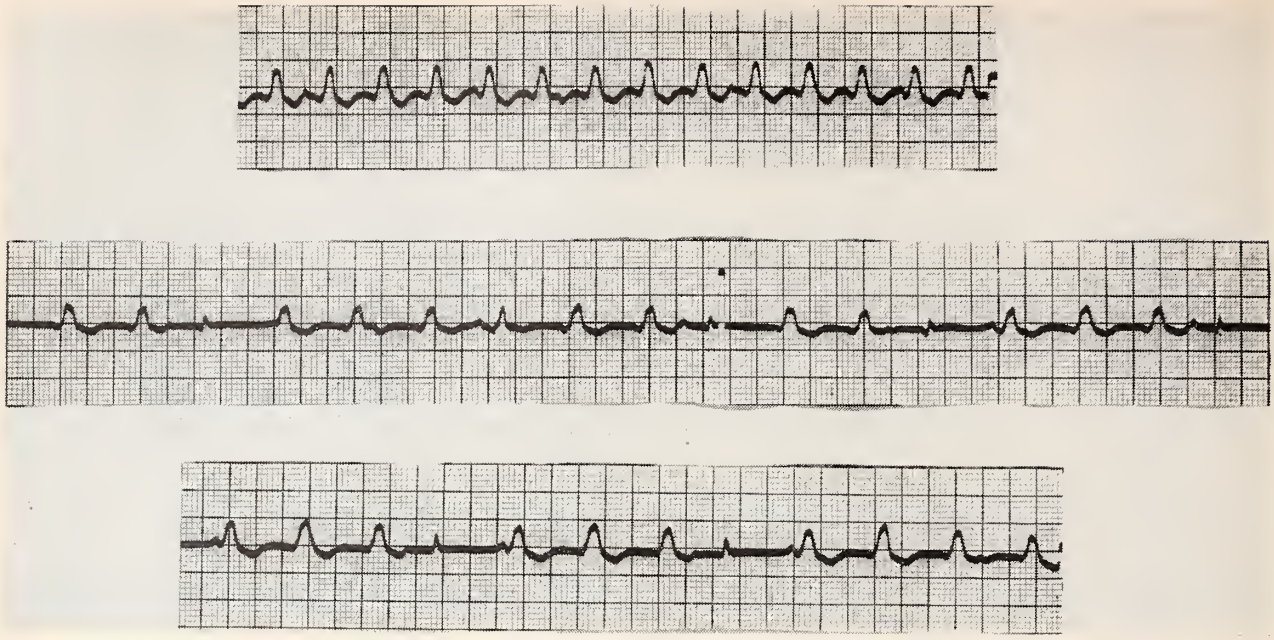


Figure 10. Description in text.

ed for ventricular tachycardia. However, continued study of this problem, re-evaluation of original and follow-up tracings, analysis of the paradoxical response to drugs and correlation of the arrhythmia with clinical status of the patients makes one realize that ventricular tachycardia is extremely difficult to diagnose with any degree of certainty. The absolute diagnosis often depends on "minor" electrocardiographic manifestations which unfortunately are not well treated in most standard books dealing with this subject. Until such "minor" phenomena become "major" ones, many supraventricular arrhythmias will be reported as ventricular tachycardia. A classical example of such an erroneous diagnosis are the many reports of ventricular tachycardia in Wolff-Parkinson-White syndrome. Most, if not all of these, are examples of supraventricular arrhythmia with aberrant conduction (Fig. 6). Similarly, many of the ventricular tachycardias supposedly due to quinidine are in reality only aberrant conduction due to the drug with accompanying supraventricular arrhythmia. We have observed a number of such cases in our hospital, the most unique example of which is represented in Fig. 5. Criteria strongly suggestive and absolutely diagnostic of ventricular tachycardia are presented in introductory remarks. However, being aware of the relative rarity of ventricular tachycardia, we are interested in finding, in any given case, signs which would tend to invalidate this diagnosis. In our experience, the following have been most helpful in suggesting that the tracing in question may not be ventricular tachycardia, but supraventricular with some form of aberrant conduction:

(1) Lack of clinical signs of heart disease and a positive response to vagal stimulation.

(2) Perfectly regular rhythm.

(3) Rate over 200 per minute.

(4) Gradual aberration of QRS complexes whenever onset of tachycardia is recorded.

(5) Lack of compensatory pause when the arrhythmia was terminated.

(6) Ventricular premature during the run of tachycardia.

(7) Capture beats with prolonged (aberrant) QRS complexes.

(8) Ventricular pattern during the tachycardia resembling right bundle branch block.

SUMMARY

1. Difficulties encountered in the diagnosis of ventricular tachycardia are stressed.
2. Signs which are strongly suggestive and findings which are diagnostic of this arrhythmia are emphasized.

3. Observations tending to refute a diagnosis of ventricular tachycardia are listed.

4. Of the material presented in this paper, the following cardiograms are rather unusual and deserving of special note:

   (1) Auricular tachycardia and fibrillation in presence of W-P-W simulating ventricular tachycardia (Fig. 6).

   (2) A-V dissociation with aberrant conduction which satisfies all the classical criteria for the diagnosis of ventricular tachycardia (Fig. 5).

   (3) Appearance of auricular tachycardia with aberrant conduction and ventricular tachycardia in same patient on different days (Figs. 1, 8, 9).

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Devoted to the interests of the medical profession of Indiana

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JENKINS-KEOGH BILL

IN THE PAST FEW YEARS the American Medical Association and the American Bar Association among many other groups of self-employed individuals have actively supported legislation designed to correct the inequity which the present federal income tax law imposes on the self-employed in regard to voluntary accumulation of retirement funds.

The following explanation of the problem and the proposed solution is quoted directly from a pamphlet published by the American Bar Association:

> THE LIFETIME INCOME CURVE OF A PROFESSIONAL MAN usually is parabolic. Income rises slowly in early years, advances rapidly to a peak where it stays for a few years, then declines gradually. The problem we face in these days of steep income taxes is how to lay something aside from those peak-earning years to provide for ourselves and families.
>
> For those of us who are self-employed there exist no ready-made retirement programs. Present tax laws render them unworkable. At the same time, millions of our fellow citizens find present income tax laws help them retire. Working for others rather than for themselves, they participate in employees' pension plans.
>
> As you know, moneys paid into these trusteed or insured plans by an employer are deemed business expense and constitute a tax deduction for the employer. More important to the employee is the fact that he does not have to pay any income tax on his company's contribution, or the increments thereto, until the benefits actually are paid out.
>
> For instance, if Mr. A, an officer of Cor-

poration X, draws a salary of $20,000 a year and Corporation X pays into its qualified employees' trust each year for Mr. A. the sum of $3,000, the taxable income of Mr. A. is not thereby increased to $23,000. Mr. A pays income taxes only upon $20,000. The $3,000 paid to the employees' trust fund for Mr. A's benefit is not a part of his taxable income until he actually receives it, plus interest earnings, from the trust some years later—usually after his days of high earned income are past. The same is true of a clerk in the office or a workman in the plant. These employed persons are having moneys paid into a trust for them and they do not currently pay taxes on such sums.

But ten million self-employed taxpayers have no such tax deferment right. When we work for ourselves we are denied equivalent assistance toward retirement.

High taxes and high living costs make it difficult for the self-employed man or woman—you, yourself—to create an old-age retirement fund out of current income.

This is true of lawyers and doctors, farmers, small businessmen, dentists, accountants—altogether some 10,000,000 private citizens. For a long time now, they and we have proposed legislation to amend the tax laws so that the self-employed might achieve a measure of equality to establish individual retirement programs similar to pension plans that grant tax deferment and retirement benefits to employees.

In the last Congress, the Jenkins-Keogh bill—the "Individual Retirement Act of 1955"—was introduced to help you and all self-employed people set aside a part of earnings for retirement. It sought to secure for you tax deferment privileges long available to those who work for others but denied those who work for themselves. Jenkins-Keogh had bi-partisan backing. Leading spokesmen for both political parties publicly endorsed its underlying principle. The glaring inequity it seeks to adjust has not a single responsible apologist. (The Secretary of the Treasury grants that present revenue laws are unfair to the self-employed).

All physicians should contact their congressman by letter or telegram to add support to a cause for the benefit of all self-employed persons.

HARVEY TERCENTENARY CONGRESS

THE TERCENTENARY of the death of William Harvey, who first described the circulation of the blood, will be celebrated in London, England on June 3 to 7, 1957. The Harvey Tercentenary Congress will meet at that time at the Royal College of Surgeons. A scientific program devoted to a review of the present knowledge of the circulation will be presented during the five-day meeting with authoritative speakers from all over the world. The International Congress on the Circulation is sponsoring the meeting. Information may be obtained by addressing the Congress Secretary, 11 Chandos St., Cavendish Square, London, W1.

PLENTY OF VACCINE

POLIOMYELITIS VACCINE has now passed from its initial phase of shortage to one of plenty. Ample supplies are available both for regular and indigent patients. Stocks of the vaccine are so plentiful that physicians, health officers and medical societies may urge the complete vaccination of all persons up to the age of 35 and even possibly up to 50.

Studies of recent epidemics of poliomyelitis have shown that the first and second injec-

tions produce considerable immunity, but that the third injection, given at an interval of seven months after the second, raises the immunization titer to a highly effective level. The present recommendations for use of the vaccine are that the second injection should be given in from four to six weeks after the first, and that the third should be given anytime after a seven month interval following the second dose.

President Eisenhower has emphasized the importance of processing the immunizations this winter in order to build up a high titer of immunity prior to the polio "season" next summer. Surgeon General Leroy Burney announced in December that manufacturers had a backlog of 23 million cc's of the vaccine. This is in addition to the stocks in pharmacies and physicians' offices, and warrants a concerted campaign for the immunization of all children and young adults.

DIPHTHERIA IMMUNIZATION FOR ADULTS

OUTBREAKS OF DIPHTHERIA during the past year, while not large, have raised the question of diphtheria immunization not only for children but also for adults. Since ordinary diphtheria toxoid is not suitable for children above the age of ten or eleven, much interest has been evinced in the production of a toxoid for adult use.

Several pharmaceutical manufacturers are working on the problem and at least one such product is now on the market. It is a combination of diphtheria and tetanus toxoid alum precipitate. The dosage is two injections of 0.5 cc. given intramuscularly four to six weeks between injections.

The use of this material on a large scale would have the great advantage of producing active immunity to tetanus, as well as increasing the number immune to diphtheria.

The last meeting of the House of Delegates of our State Association resolved that the state of Indiana should work diligently toward universal immunization against tetanus. All citizens of the state should be informed concerning the importance of complete and universal immunizations against these two diseases, and indeed should be acquainted with the advantages of the use of all standard immunizing agents.

Guest Editorial:

STANDARDS IN THE PHARMACEUTICAL INDUSTRY

SUSPENSION of clinical trial of carbutamide (BZ-55) has been announced by the Eli Lilly Company. The drug, a derivative of sulfanilamide, lowers blood sugar levels and had been hailed as an answer to the long search for an oral substitute for insulin. It had been tested in Germany where no serious reactions were reported after trial in 40,000 patients. In the pilot study on 700 patients in this country, no difficulties were encountered.

Desire on the part of the manufacturer to rush such a preparation to an avid market would be understandable. Caution displayed in further careful testing reveals the responsibility of the reliable pharmaceutical houses in this country.

After pilot study, the drug was placed in the hands of some 2,900 physicians who observed results in more than 10,000 patients. It was effective in controlling many cases of diabetes but a few reactions began to appear. Finally it was determined that about 5 per cent of patients would display unfavorable reactions. They were similar to those observed following administration of other sulfonamides.

The Lilly Company, in reporting withdrawal of the drug from further tests, stated that its

action was based on the realization that this was a drug of convenience rather than necessity. Regret was expressed that it did not meet the rigid requirements for a drug to be taken throughout life. The company, however, was grateful that the study had been broad enough and thorough enough to uncover its limitations.

The amount of money invested in research on this drug was probably quite large. The quick profits which might have been garnered can only be the subject of conjecture. Willingness to write off the loss and to forego the profits is characteristic of modern, far-sighted management of our reliable drug manufacturers. Undoubtedly, all of them have had similar experience with other preparations after preliminary favorable reports. Undoubtedly, all of them make heavy investments in research, only a small part of which produces information on which profit may be realized. Their major gain is in the confidence of the profession which needs to rely on products marketed under such high standards.

Action of the Lilly Company in withdrawing carbutamide illustrates something much more important, however, than the experience of one company with one new drug. On careful analysis it is quite obvious that the Lilly Company, or any other private manufacturer, will achieve a stronger position, will market more products and make more profit if it continues to follow a policy of honesty and sincerity. These are selfish motives but by refusing the quick profit and by exercising great care before marketing a new drug, the pharmaceutical houses also demonstrate a high degree of morality and admirable acceptance of responsibility. With such acceptance there seems to be some question as to the necessity of a governmental bureau to set standards for a conscientious industry.

The important thing demonstrated is that a great industry has accepted the rule about honesty being the best policy.

—*Northwest Medicine*
(December 1956)

THE EIGHTY-THREE MEDICAL SCHOOLS TEACH 27,000 MEDICAL STUDENTS GRADUATING MORE THAN 6,600 ANNUALLY — INVEST BY GIVING TO THE AMERICAN MEDICAL EDUCATION FOUNDATION

The President's Page

TWO GREAT AMERICANS—FEBRUARY'S SONS

"PUT ONLY Americans on guard tonight" was said to have been one of George Washington's General Orders at one of the low spots of the American Revolution, when his army was beset with cold, hunger, lack of supplies, and, even worse, by human defection through Tories, spies, deserters and traitors. But, consider for a moment those men selected for guard duty under such an order! Do you not suppose their visual acuity was sharpened, their auditory perception heightened and their thoracic expansion increased?

And today, when we have the opportunity to serve our country either directly in the armed forces or in combatting subversive propaganda, should we not feel some added pride? One of our national by-words has been—"Let George do it!" George did it all right, and now we must do our share and continue to do so.

Abraham Lincoln expressed hope and faith in the ultimate triumph of true democracy, when he inquired in his First Inaugural Speech,—"Why should there not be a patient confidence in the ultimate justice of the people? Is there any better or equal hope in the world?" A cynic might have remarked that he was more likely to say it than his worthy opponent, but the idea expressed is enduring.

Both Washington and Lincoln had a true and abiding belief in liberty and freedom. Both would have tried to stop the advance of Communism, had they been faced with it in their time. We want no war, knowing that few things are settled permanently by resort to arms, but we should be able to lend assistance to those whose lives have been disrupted by the forces of Communism. I refer to the unfortunate people of Hungary, who have been forced to leave their homes and seek shelter where they may in adjoining countries. Dr. M. C. Topping comes forward with the suggestion, and I think it a good one, of sending funds from the Indiana State Medical Association Treasury for "Hungarian Medical Relief". A vote is now being taken among the Council and Executive Committee members as to whether to do this, and if so, how much? I should like to go further, and urge each of you regardless of whether the State Medical Association aids or how much to contribute of your own funds in this worthy cause. Send checks to "Hungarian Medical Relief" to our state office. These Hungarian refugee physicians are having to aid in caring for the sick among the entire refugee group, but will doubtless be called upon for rehabilitation work in Hungary if and when this awful scourge passes.

I wish to thank you all for your aid in committee work. I think the Indiana State Medical Association is getting away to a great start. Some very fine ideas were presented at the big joint committee meetings.

Elton R. Clarke, M.D.

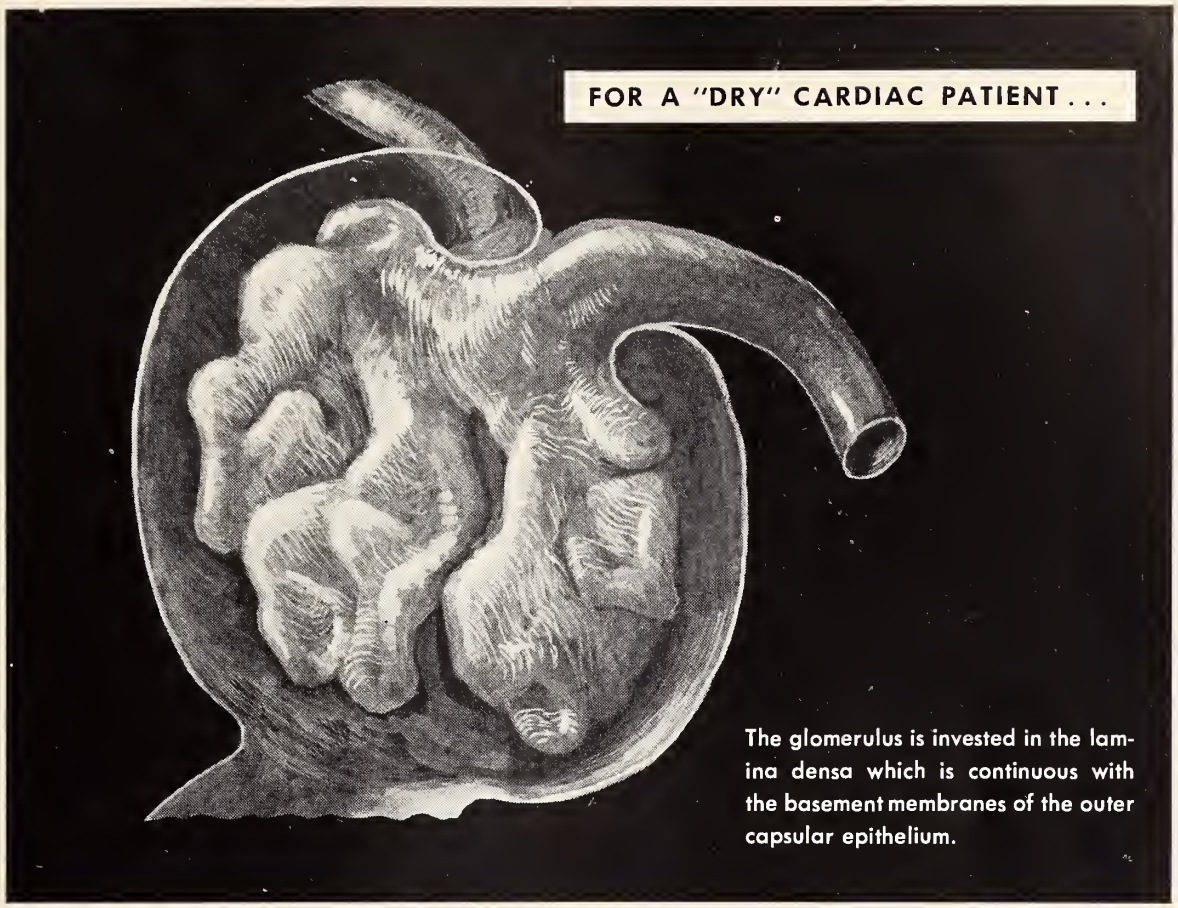

Illustration by Hans Elias

Rolicton® Diuresis Maintains Continuous Edema Control

The efficacy of Rolicton (brand of amisometradine) in maintaining diuresis in the edematous patient has been established on an average dosage of one tablet b.i.d. Larger doses may be given as initial therapy and as maintenance therapy in edema difficult to control. Many patients will respond to one tablet daily.

"The margin of safety and the diuretic index is certainly an improvement over the use of oral mercurial diuretics."[1]

Avoiding "Peaks and Valleys"

A highly desirable effect, and one which has been made possible with Rolicton, is the maintenance of continuous diuretic effectiveness day after day over an extended period, to avoid the up-and-down weight pattern typical of other edema-control methods.

"There was an obvious stabilization of weight in practically all of the patients under observation, and previous wide fluctuations in poundage disappeared."[2]

Mercury-Sparing

Typical of the Rolicton diuresis pattern is the ability of the drug to reduce and, in a large percentage of patients, to eliminate the need for mercurials parenterally.

". . . the drug represents a most useful addition to our armamentarium in the treatment of edema, not only because it can be given orally . . . but more so because it permits [us] to replace or to spare the . . . mercurials."[3]

G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

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SEARLE

The Woman's Auxiliary

REPORTS TO I.S.M.A.

The Hoosier Doctor's Wife is the official publication of our State Auxiliary, and we are very proud that it ranks foremost with the news-letters of other states.

In 1947, Mrs. A. W. Ratcliffe of Evansville was instrumental in inaugurating a State Auxiliary paper which she named *The Hoosier Doctor's Wife,* and this has been our official publication ever since. Following Becky Ratcliffe, Mrs. Richard B. Stout of Elkhart served as editor for several years.

Mrs. Green

At the present time, our paper is edited by **Mrs. Frank Green** of Rushville, and she came to us with a world of background experience in newspaper work. Jean was the Woman's Editor of the *Washington Post,* Washington, D.C., when she married Dr. Frank and moved to Rushville. However, she is a native Hoosier, for she is the daughter of the late Dr. William L. Green of Pekin. Her brother, Dr. William Green, is an orthopedic surgeon in Boston, Massachusetts.

Her efficient staff includes:

Mrs. Joe M. Black, Seymour, associate editor.

Miss Frances Phares, Shelbyville, county news editor. Frances is the daughter of the late Dr. Henry Phares, Shelbyville.

Mrs. E. W. Nahrwold, Fort Wayne, biographical editor.

Mrs. Black

Miss Phares

(Photograph of Mrs. Nahrwold was not available.)

Our *Hoosier Doctor's Wife* has eight full pages, and is published and mailed to each Auxiliary member four times a year at a cost of $250 an issue. We are very proud of our state publication.

PUBLICITY CHAIRMAN

Mrs. Schuster

Mrs. Dwight Schuster, Indianapolis, is doing a bang-up job as our Publicity Chairman. As we can see by the state newspapers, Anne has been able to get good publicity for us. She has had both pictures and articles in all three of the Indianapolis papers and has developed a friendly feeling by her contacts with them. We owe her a great deal for helping us improve medical public relations.

AMA BULLETIN CHAIRMAN

Mrs. Weirich

Mrs. Charles Weirich, Butler, serves as our State *Bulletin* chairman. The *Bulletin,* our national publication, is sent us four times a year at the subscription price of $1.00. Through the pages of this quarterly we learn what is happening in other states, and gather ideas to further our Auxiliary projects. Maxine urges each member to read the *Bulletin.* She sends in subscriptions as soon as she receives the order.

Mrs. Holland

Mrs. Philip T. Holland, Bloomington, is serving as our Historian. Ellen writes: "The Woman's Auxiliary holds a valued place in the medical field. Groups have contributed toward favorable publicity, public relations, rural and school health, nurse recruitment, medical care insurance, and to A.M.E.F. Kipling once wrote in 'The Elephant's Child':

> I keep six honest serving-men
> (They taught me all I know);
>
> Their names are What and Why and When
> And How and Where and Who.

Let these 'six honest serving-men' be the basis for material sent in to be recorded permanently. Keep our archives complete for future reference, entertainment and history."

Thus, with her as our Historian, our records of the work and accomplishments of all our Auxiliaries and their committees will be both interesting and most complete for posterity.

Julia Tindall

MRS. WILLIAM R. TINDALL, *President*

Senator Bricker Introduces a New Treaty Amendment

SENATOR BRICKER (R., Ohio) is renewing his efforts to protect domestic law against possible encroachment by treaties. He has presented a new version of a constitutional amendment, an earlier version of which was defeated in the Senate by a one-vote margin in 1954. Although Senator Bricker conferred with President Eisenhower before offering the new resolution, he did not indicate whether he had won the President over to the new provisions. It was largely through opposition of the President that the earlier proposal was defeated. The AMA supports the Bricker amendment in principle. The new version reads:

> Section 1. A provision of a treaty or other international agreement not made in pursuance of this Constitution shall have no force or effect. This section shall not apply to treaties made prior to the effective date of this Constitution.
>
> Section 2. A treaty or other international agreement shall have legislative effect within the United States as a law thereof only through legislation, except to the extent that the Senate shall provide affirmatively, in its resolution advising and consenting to a treaty, that the treaty shall have legislative effect.
>
> Section 3. An international agreement other than a treaty shall have legislative effect within the United States as a law thereof only through legislation valid in the absence of such an international agreement.
>
> Section 4. On the question of advising and consenting to a treaty, the vote shall be determined by Yeas and Nays, and the names of the Senators voting for and against shall be entered on the Journal of the Senate. —*AMA Washington Letter.*

"Monganga" to Be Retelevised in Response to National Demand

OVERWHELMING RESPONSE from physicians, churchmen, television writers and viewers has prompted March of Medicine to repeat its hour-long documentary on missionary medicine Tuesday, March 5, at 9:30 p.m. EST over the NBC-TV network.

This latest in the prize-winning TV series, produced and sponsored by Smith, Kline & French Laboratories in cooperation with the American Medical Association, is called "Monganga," tribal dialect for "White Doctor." Originally televised November 27, it brought a heavy flow of enthusiastic letters, telegrams, phone calls and personal messages—many asking to see the program again.

Among the nation's television critics, Jack Gould of the *New York Times* called Monganga "an absorbing hour-long documentary on the work of a missionary doctor in a remote village of the Belgian Congo." Jay Nelson Tuck of the *New York Post* felt that "beautiful photography, skillful editing and a script of simple directness combined to tell an inspiring story."

Writing for the Associated Press, Charles Mercer called Monganga "one of the most moving and absorbing documentaries in many months." Hal Humphrey in the *Los Angeles Mirror-News* described it as "a tremendous human interest story."

Monganga's November showing marked a significant "first" for this pioneering TV series. It was the first hour-long medical program ever presented coast-to-coast in compatible color and black-and-white.

The show chronicles the daily labors of one missionary, Dr. John Ross, as an "illustration of the work American doctors are doing for sick people all over the world."

In Doctor Ross' clinic, surgery is always preceded by a prayer. He is shown at his 14-hour day—overseeing a nearby leprosarium, conducting a weekly pre-natal clinic, traveling to distant "bush clinics."

". . . TO LIFT THESE PEOPLE UP"

His days not only include the diagnosis and treatment of diseases which face all physicians everywhere, but also the very special challenge of tropical medicine. Leprosy, yaws, elephantiasis and sleeping sickness are encountered daily. Primitive living and sanitary conditions must be improved—and often Doctor Ross turns field construction engineer.

"My job," Doctor Ross says simply, "is to lift these people up."

This dedicated man is a Kansan by birth who, as a minister, served congregations in California. At the age of 36—after the death of his first four children, two of them within 10 days—he decided to become a medical missionary. He graduated from the Indiana University School of Medicine and took graduate work at Tulane

Please turn to page 208

Artificial Arms Return Wearer to Normal Life

Dwight McGee of Lancaster, Ohio, wearing two Hanger Arms, can write, shave, use a knife and fork, drive an automobile, and says he can do about anything an ordinary person can do. Hanger Arms are custom-made to fit the wearer's stump and his particular daily needs, and are carefully fitted by experienced Hanger fitters. Arms can be furnished with cosmetic or mechanical hand and hook.

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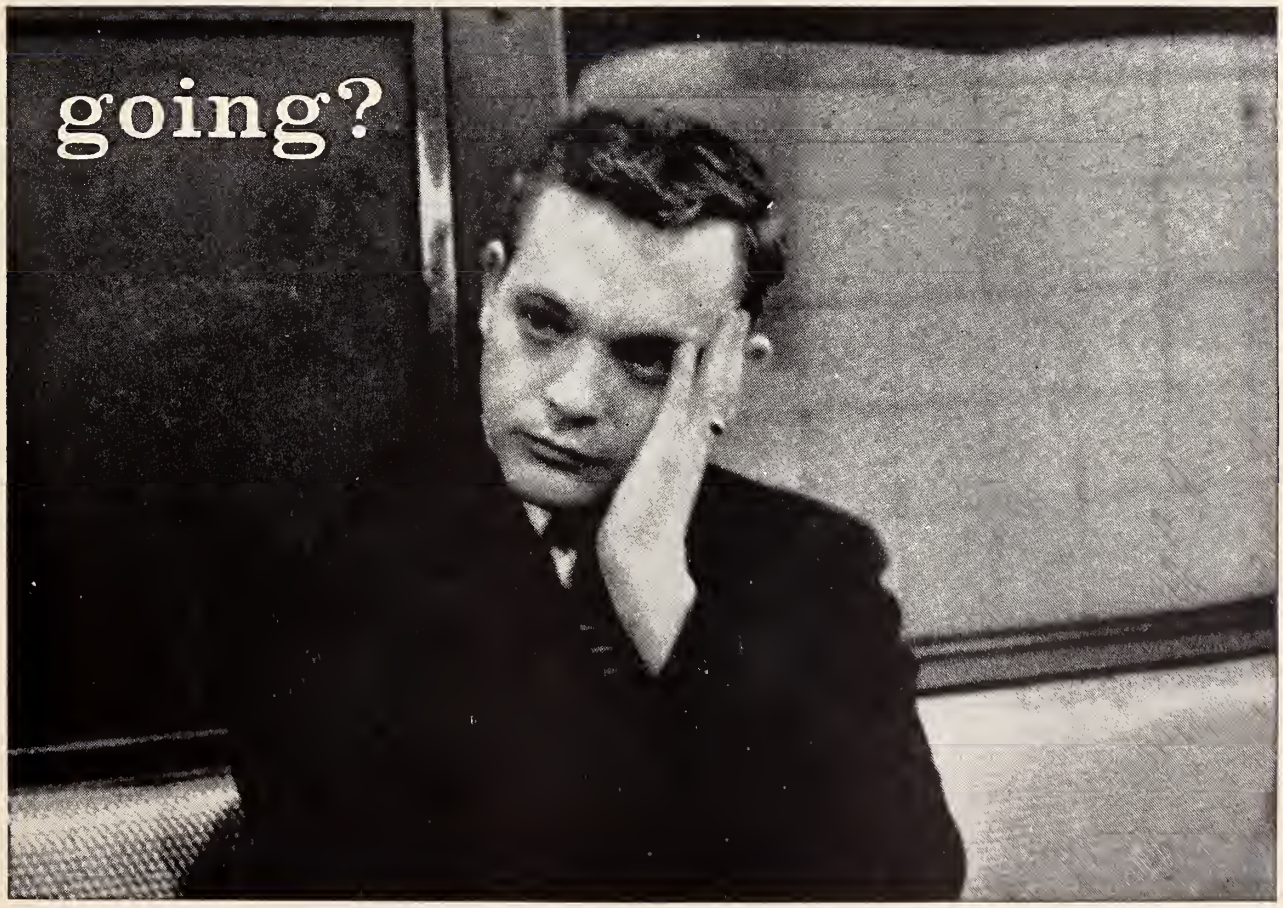
where is this man



Four Cases of Leukemia Reported in One South Dakota Family

THE CHANCES OF LEUKEMIA, a serious blood disease, occurring in more than one member of a family are exceedingly small, but when it does occur, it may result from some hereditary factor, three North Dakota physicians report.

Drs. Marlin J. E. Johnson and Clifford H. Peters, Bismarck, N. D., observed the development of three cases of acute leukemia and one of lymphosarcoma (a related disease of the lymphatic tissue) among four of 12 children in a North Dakota farm family during 1952-54.

Only two other families in which more than two children had leukemia or lymphomas have been reported. Five of eight children in one family had acute leukemia, while four of seven children in the other family had either leukemia or lymphomas, the doctors said in a recent *Journal* of the American Medical Association. A world-wide survey in 1953 revealed only 12 other families in which two children had acute leukemia.

Three brothers, aged 24, 26 and 29, and one sister, aged 33, were all fatally affected.

The chances of four cases occurring in a family of 12 children are about five in one billion, the authors said. They did not believe that the chance played a part in these cases. Neither did environmental factors. Rather they believed that heredity played a major role in these cases, especially when they learned that the parents of the children were first cousins. Their grandmothers were sisters and their grandfathers were believed to have been fourth cousins.

The doctors noted that one of the other two families with more than three affected children was also the result of a marriage between relatives. And it is "a well-known genetic fact" that the frequency of rare diseases due to inherited characteristics is greater among children resulting from marriages between relatives than among the general population.

The uniform age of onset and the similar, rapidly progressive nature of the disease in the four patients also suggested a hereditary factor, they said. Twenty-nine of the patients' first cousins lived in the same area and none of these cousins suffered any sort of malignancy. However, none of these cousins was the offspring of consanguineous marriage.

The failure to find any environmental agents as the cause of the disease does not mean that they do not exist, the authors said. However, "if they do exist, we are still confronted with the necessity for explaining why some of the children contracted leukemia, while others did not."

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"Monganga" to Be Retelevised
(continued)

University. In 1950—by then 43 years old—he was assigned to the Disciples of Christ mission in the village of Lotumbe.

John Gunther, author of "Inside Africa," is the principal commentator for the program, providing background on Africa and on the work of the medical missionary.

March of Medicine was the first television series to receive an Albert Lasker Award for Medical Journalism. In the past, the series has focused on such topics as mental health, cancer, heart disease, arthritis, and new surgical techniques.

A mobile chest x-ray unit traveled to different parts of the city for a week. On the last day the attendant noticed a woman whose face seemed familiar.

"Haven't you had an x-ray before?", he asked.

"Oh yes," she replied enthusiastically. "This is my fifth trip, and I can't tell you how much better the treatments are making me feel!"

—one of the five Patient Units

HARDING SANITARIUM WORTHINGTON, OHIO
Telephone Columbus, TUxedo 5-5381
FOR NERVOUS AND MENTAL DISORDERS

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L. Harold Caviness, M.D., *Clinical Director*
Charles W. Harding, M.D.

Postgraduate Courses, Other Events Scheduled for I.U. Medical Center

MARCH 4, 5 and 6 are dates selected for a postgraduate course in electrocardiography at Indiana University Medical Center, Indianapolis, under the direction of Dr. W. Donald Close.

Dr. Carl P. Huber has scheduled a postgraduate course in obstetrics and gynecology on March 6 and 7.

Other refresher courses planned by department heads at the medical school include:

Orthopedics (Dr. George J. Garceau)—March 13.

Gastrointestinal Bleeding (Dr. H. B. Shumacker)—March 14.

Otolaryngology (Dr. Marlow Manion)—March 25—April 6.

Hematology (Dr. Robert J. Rohn)—May 1.

Cardiology (Dr. W. Donald Close)—May 20-21.

The Ball Visiting Professor on March 17 will be Dr. John H. Mulholland, New York City surgeon. Dr. Shumacker is in charge of plans.

On March 20 the Kirkpatrick Memorial Symposium on Gerontology will be held under the chairmanship of Dr. John VanNuys, dean.

Dr. Rohn will present the Annual Cancer Symposium on April 26-27.

State Medical Board examinations are scheduled for June 19, 20 and 21 with Miss Ruth V. Kirk, secretary, in charge.

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THAT HEALS

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All Services
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Erythromycin in Treating Pneumonia

A 27-year-old man, a chronic alcoholic, was admitted with a history of an alcoholic spree followed by a cough, greenish sputum and chills and fever.

Physical examination showed a temperature of 104 F. and indicated pneumonia in the right lower lobe. This was confirmed by X-ray. The sputum revealed gram-positive diplococci and blood culture subsequently grew Type VII pneumococci.

The patient was treated with erythromycin, 300 mg. every six hours per os. His temperature dropped to normal by 48 hours and X-ray of the chest revealed considerable clearing by the fourth hospital day. After 10 days hospitalization, the patient was fit for discharge.[1]

First Antibiotics Symposium, we reported the successful treatment with thromycin of *H. influenzae* pneumonia and bacteremia. A second patient with *H. influenzae* pneumonia and bacteremia had a clinical course almost identical to the one previously reported, with cure obtained by treatment with 500 mg. of erythromycin per os every four hours for 14 days.

Of these 132 patients with bacterial pneumonia, 127 (96%) had a good clinical result. One patient with lobar pneumonia had a good initial

"Highly Effective in Pneumonia"

In one investigation, 75 adult patients with bacterial pneumonia were treated with erythromycin. In his summary, the clinician reported: "It is concluded that erythromycin is highly effective in the treatment of pneumonia due to gram-positive bacteria."[2]

This, of course, is only one of many reports showing the effectiveness of ERYTHROCIN against coccic infections. You'll get the same good results (nearly 100% in common, bacterial respiratory infections) when you prescribe ERYTHROCIN. Abbott

filmtab®

Erythrocin®

(Erythromycin, Abbott)

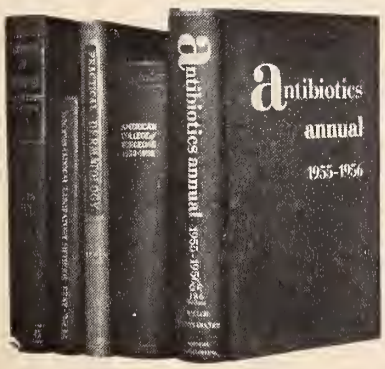
STEARATE

"No Serious Side Effects Occurred"

After a study of 171 patients treated with erythromycin, the investigator wrote: "No serious side effects occurred with prolonged therapy or with doses up to 8 Gm. per day in the severe infections."[1]

Actually, ERYTHROCIN stands on a remarkable record of safety. After four years, there's not a single report of a severe or fatal reaction attributable to erythromycin. In addition, you'll find allergic manifestations rarely occur. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), in bottles of 25 and 100. Abbott

® Filmtab—Film-Sealed tablets, Abbott; pat. applied for.



1. Romansky, M.J., et al., Antibiotics Annual 1955-1956, p. 48.
2. Waddington, W. S., Maple, F. C., and Kirby, W. M. M., A.M.A. Archives of Internal Medicine, 1954, p. 556.

7010-1

Details Announced for Centennial of Cincinnati Academy of Medicine

THE ACADEMY OF MEDICINE of Cincinnati cordially invites all physicians, their families, and their patients to its 100th Birthday Party, February 27 through March 5, 1957. In order to officially observe the occasion, a Health Museum and Exposition will be established in Cincinnati's spacious and historic Music Hall. One hundred and seventy-five health and scientific exhibits, representing medicine, hospitals, research centers, public health, nursing, pharmacy, and industry will be displayed in the north and south halls. Notable among these exhibits and occupying some 4,000 square feet of space, will be an atomic energy exhibit from the American Museum of Atomic Energy entitled "Atoms for Peace."

In the main foyer of the hall, "Juno," a full-sized, activated manikin, graciously loaned for the occasion by the Dominican Republic, will be on display, Juno is operated electrically, and with concurrent recorded narration, will demonstrate blood vessels, bones and organ structures of the body.

The ribbon cutting ceremony for the Centennial Exposition will be conducted by the Honorable William O'Neil, Governor of the State of Ohio, at 9:00 A.M., on Wednesday, February 27, 1957.

Dr. Paul D. White and Dr. Walter Alvarez, noted medical scientists and authors, have accepted invitations to be among the distinguished guest speakers.

The Centennial Convocation will be held on the last night of the Exposition, March 5, 1957. The Convocation address will be given by Sir Edward Appleton, Nobel Laureate, Edinburgh, Scotland, and civic leaders, officials of both the American and State Medical Associations, and government dignitaries will take part in the elaborate ceremonies.

Professor Reginald McGrane, Chairman of the Department of History, University of Cincinnati, has prepared a one hundred year history of the Academy of Medicine, entitled "The Doctor's Forum." Copies of this volume will be available at the Centennial Exposition.

The Cincinnati Journal of Medicine also is preparing a special Centennial Edition for the occasion.

It is anticipated that 500,000 people will be on hand at the Music Hall as an assurance that the Academy of Medicine's Centennial observation will be an historic event.

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WABASH VALLEY SANITARIUM—HOSPITAL

Lafayette, Indiana
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A hospital for the treatment of neuro-psychiatric disorders.

Custodial cases are accepted in limited numbers.

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'EMPIRIN' COMPOUND®

with CODEINE PHOSPHATE

shortens the "miserable" period by:

- Reducing fever
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prompt symptomatic relief of colds with ***minimum addiction liability***

Available in four strengths

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Excerpts from the First Volume

Scanning the pages of the first volume of The JOURNAL of the Indiana State Medical Association (1908) we read of the death of Nicholas Senn, former professor of surgery in Rush Medical College . . . the marriage of Dr. Thomas J. Beasley and Miss Nellie Loomis of Indianapolis . . . and Drs. William Shimer and H. R. McKinstray completed their internships at Indianapolis City Hospital and opened offices for private practice . . . Dr. Kenneth I. Jeffries, who had been physician at the Eastern Insane Hospital at Richmond, went to New York for a few months of clinical work prior to entering practice at Indianapolis . . . Dr. E. B. Mumford moved from New Harmony to Indianapolis . . . Dr. Edgar F. Kiser, superintendent of the Indianapolis City Dispensary, was married April 14 to Miss Cleone Hene of Muncie . . . and Dr. Noah D. Berry of Muncie was recovering from a fall on an extended hand in which he sustained a Colles fracture.

"On the Banks of the Wabash"

AN INSTITUTE OF

PHYSIOLOGICAL THERAPEUTICS

Illustrated Catalogue mailed to any address upon request. Address

WABASH VALLEY SANITARIUM
LAFAYETTE, IND.

During that same year the Wabash Valley Sanitarium of Lafayette placed an advertisement in The JOURNAL which is reproduced here. In 1957, they are still among our faithful advertisers. This month's advertisement appears on page 212.

Indiana University began placing modest announcements of the full four years' course offered by the School of Medicine.

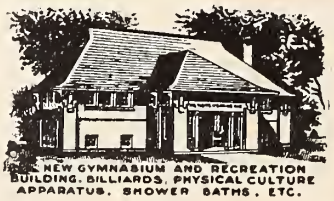
Milwaukee Sanitarium placed the advertisement reproduced here in the May, 1908 issue and that institution continues to carry

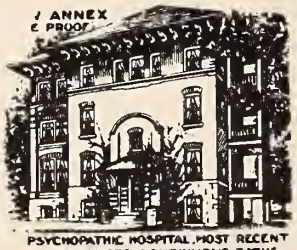
Please turn to page 218

INDIANA UNIVERSITY SCHOOL OF MEDICINE
FULL FOUR YEARS' COURSE
Laboratory Years Given at University, Bloomington; Clinical Years at Indianapolis, in connection with State College Hospital.
For Bulletins and Information address, Dr. B. D. MYERS, Secretary, Bloomington, Indiana.

The Milwaukee Sanitarium

Established in 1884





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Situated in the beautiful suburb, WAUWATOSA, Wis. Extensive improvements recently made, together with facilities previously in use provide an equipment of great completeness. Wide separation of the FIVE different houses, giving individualized treatment and environment for all. Ideally beautiful grounds (25 acres) "set on a hill." Modern Bath house. Secluded, yet convenient of access. On C., M. & St. Paul R'y, 2½ hours from Chicago, 15 minutes from Milwaukee. Two lines street cars, 5 minutes' walk from all cars. CHICAGO OFFICE, Venetian Building, 34 Washington St. Office hours; Wednesdays 2 to 4 (except July and August). Telephone connections. Address,

DR. RICHARD DEWEY, Med. Supt., Wawautosa, Wis.

Cool comfort for hot itching dermatoses

'HYDROBALM'

(HYDROCORTISONE-CALAMINE LOTION & CREAM)

There's no waiting for relief when you prescribe HYDROBALM for patients with inflammatory and pruritic dermatoses. In a matter of seconds HYDROBALM suppresses distressing symptoms, hides unsightly lesions, and sets the stage for healing. HYDROBALM—Cream or Lotion—presents in two convenient, delicately scented, water-washable flesh-tone greaseless vehicles, 4 therapeutically proved agents: 'Hydrocortone' (Hydrocortisone, U.S.P.)—0.5%—to suppress inflammation. Calamine—8%—to soothe and protect inflamed skin. Benzocaine—3%—to relieve itching and pain. Hexylated Metacresol—0.05%—for antisepsis.

Supplied: Topical Lotion HYDROBALM—in 15-cc. and 30-cc. handy, purse-size, plastic squeeze bottles. Topical Cream HYDROBALM—in 5-Gm., 15-Gm. and 30-Gm. tubes.

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The pain Dad feels now is the beginning of tenosynovitis. With adequate early treatment he'll be able to stay on his job. Delaying therapy might result in the development of effusion and, later, calcification of ligaments or even periarthritis with severe pain and serious restriction of movement.

Immediate antirheumatic therapy is to be encouraged in the treatment of tenosynovitis, as it should be in the majority of other common rheumatic disorders, to alleviate pain and prevent progression of the disturbance to a point of irreversible damage.

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corticoid-analgesic compound **Tablets**

for patients who go beyond their physical capacity

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Excerpts

(continued)

a monthly insertion. This month's advertisement is on the back cover, a position they have held since 1931.

Also on the JOURNAL's 50-year honor roll is French Lick Springs Hotel, now the French Lick-Sheraton. The hotel has been the meeting place in alternate years of the Indiana State Medical Association during most of the intervening period.

French Lick Springs Hotel

French Lick Springs

THE CARLSBAD OF AMERICA

Sulpho-saline-alkaline Waters

INDICATIONS—Gastro-intestinal, Hepatic and Renal Diseases, Diabetes, Gout, Obesity, etc.

A PERFECTLY APPOINTED MODERN HOTEL WITH FACILITIES FOR SANATORIUM TREATMENT

Sulphur, Electric Light and Turkish Baths; Massage and Electro-therapy

1200 Acres of Park Land—Golf, Tennis, Riding and Driving

INDIANA STATE MEDICAL ASSOCIATION

Meets here, June 18-19, 1908

GEORGE D. KAHLO, M. D., Medical Director — THOMAS TAGGART, President

PLUTO

Definitely not in the "then and now" class are the three advertisements grouped on page 218, depicting a leather medicine case for $5.75, automobiles from $100 up, and a surgical operating table for $50. These early day advertisers offered bargains at what appear to be ludicrously low prices.

That first issue of The JOURNAL back in January 1908 represented a radical change from the formal Transactions which had been the official publication of ISMA prior to 1908. The initial number actually carried a colored illustration for a scientific article on "Spina Bifida" by Dr. Miles F. Porter of Fort Wayne. There were 14 black and white illustrations. The JOURNAL contained 68 pages and had a self cover. Unfortunately, there are no records of the cost of that first issue, however, based on first figures which are available, it is estimated the production cost of 3,000 copies of No. 1 was about $200.

Next month additional "Fifty Years Ago" news and advertising will be reproduced.

Editorially, we will tell of our successful search for a complete bound volume of the 1908 issue. The volume in The JOURNAL's files lacked the March 1908 issue.

No. 204 Medicine Case, Price Only $5.75

This case is made of black seal grain bag leather, hand stitched around edges. Dimensions, 11 in. long, 4 in. wide and 6½ inches high. Has lock and key and is fitted with metal springs for holding bottles. It contains 16 1-oz., 16 3-dram vials, also 4 1½-oz. metal cap bottles. Supply space 5 x 4 x 1½ in. There is no better case in the market for the money.

Send for our latest catalogue.

PHOENIX LEATHER MFG. CO. 172 Grand Ave., CHICAGO, ILL.

AUTOMOBILES $100 AND UP

We will mail our large Illustrated Bargain Sheet of new and slightly used Automobiles on request. This sheet shows accurate photographic views of more than 50 Automobiles offered as low as $100. Every car guaranteed as represented. Write to-day to.

A. L. GRAHAM AUTOMOBILE CO.

Established 17 years. 601-603-605 Madison St., Chicago, Ill.

A Rare Bargain GARLAND SURGICAL OPERATING TABLE

Illustration represents but one of the many radical positions, which can be multiplied by various combinations of the several adjustments. It is clearly ahead of all others except in high price. Combining in a surgical and gynecological table, and adjustable top with adjustable leaves and arm rest, a cabinet of drawers opening to either side, a cupboard with glass shelves, swinging glass shelves with glass trays, all finished inside with white enamel, and outside in highest piano polish finish.

Dimensions. Length, 5 feet 6 inches; width, 22 inches; height, 34 inches. Weight packed for shipment about 200 pounds.

PRICES. Best Golden Oak Polished Finish, quartered oak, full cabinet four drawers, three glass trays, nickel-plated trimmings, leather top cushions and pillow, leg and arm rests. List Price ..... $80.00. Our Price $50.00

Our 750 page Illustrated Surgical Instrument Catalog sent *Free* per *Express Prepaid* upon receipt of your request.

Established 1844 **SHARP & SMITH** Incorporated 1904

Manufacturers of High Grade Surgical and Veterinary Instruments and Hospital Supplies

92 Wabash Ave. 2 Doors North of Washington St. Chicago, Ill.

We are the LARGEST manufacturers of SURGICAL ELASTIC GOODS in the United States.

Deaths . . .

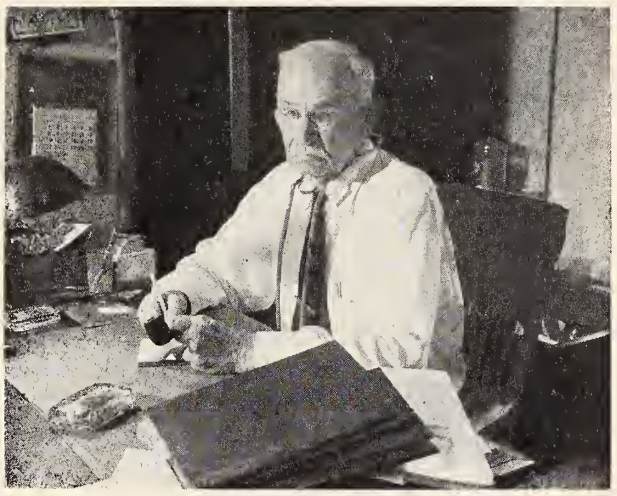
William H. Stemm, M.D., former president of the Indiana State Medical Association, died in Schneck Memorial Hospital, Seymour, on December 16 just one hour after he had been admitted following a fall in his North Vernon home. He was 95 but was still in limited practice and was the oldest practicing physician on the Schneck hospital staff and one of the oldest in Indiana.

Doctor Stemm became president of the Indiana State Medical Association and served in 1918-1919 after coming up through the ranks of organized medicine in Indiana. He had served Jennings County Medical Society as secretary, the Fourth Councilor District as councilor from 1905 to 1918, was first vice-president of the state association in 1907-1908, was an alternate delegate to the American Medical Association in 1916 and 1917, before being named president-elect of ISMA in 1918.

Since that time he had continued his interest in affairs of the state association and his county society. He was serving as Jennings County Medical Society president at the time of his death, a post he had held since 1947.

Doctor Stemm was born in Maryland but had lived in the North Vernon community since he was a young man. He received his medical degree from the Medical College of Ohio at Cincinnati in 1887. He had been in the active practice of medicine for 69 years.

Doctor Stemm was a Fifty Year Club and senior member of the Indiana State Medical Association and a member of the American Medical Association.



The Dr. William H. Stemm most familiar to thousands of patients during his 69 years of active practice is pictured here. His death on December 16 ended a career in the practice of medicine which gained him the respect of fellow physicians and patients throughout southern Indiana. The photograph was taken in his North Vernon office by a Louisville Courier-Journal photographer.

Helmuth C. W. Ernst, M.D., 64, East Chicago physician and public health official since 1917, died November 26 in his home. He had been ill for several months.

Doctor Ernst was a native of Illinois. He was graduated in 1917 from the Chicago College of Medicine and Surgery (Loyola) and established his practice in East Chicago the same year. During World War I he served as a major in the Army Medical Corps. On his return he reestablished his practice and through the years had served as medical director for several industrial plants and was secretary of the East Chicago Health Department until a few months ago.

Doctor Ernst was a member of Lake County Medical Society, the Indiana State and American Medical Associations, and also held church and lodge memberships.

Ernest A. Kellen, M.D., 51, died at his Indianapolis home January 8. He had been a member of the staff of Central State Hospital for three years.

Doctor Kellen was a native of Duluth, Minnesota and received his medical degree from St. Louis University School of Medicine

in 1948. He studied for a doctorate at Indiana University.

He was a member of the American Medical Association, American Psychiatric Association, and the New York Academy of Science.

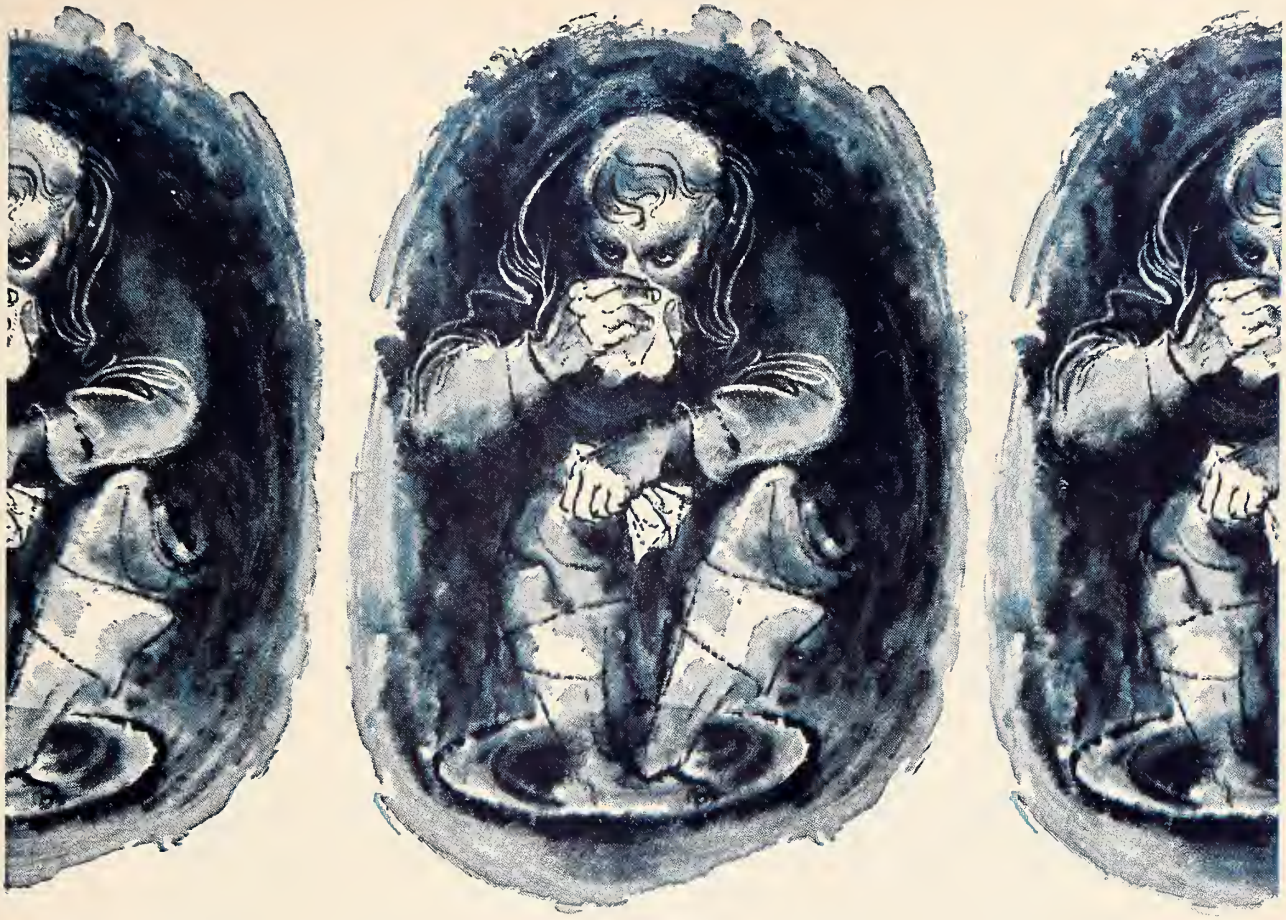
Joseph H. Ward, M.D., 86, died in the West 10th Street VA Hospital in Indianapolis December 7.

Born in North Carolina, Doctor Ward had lived in Indianapolis for 60 years. He was a graduate of the Physio-Medical College of Indiana in Indianapolis. He received his degree in 1897.

After serving as a colonel in the Army during World War I, Doctor Ward became superintendent of the Tuskegee Veterans Administration Hospital in Alabama where he remained for 12 years. He then returned to Indianapolis and for many years had an office at 2116 Boulevard Place.

He was active in YMCA work, was a founder of the Senate Avenue branch of the YMCA, and a former vice-president of the YMCA Metropolitan Board. He had been active for many years in his church and in Masonic bodies.

Doctor Ward was a member of Indianapolis Medical Society, the Indiana State Medical Association and the American Medical Association.



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TETRACYCLINE-ANTIHISTAMINE-ANALGESIC COMPOUND

Tablets and Syrup

ACHROCIDIN is particularly valuable in treating acute respiratory infections during epidemics or when questionable middle ear, pulmonary, nephritic, or rheumatic signs are present.

ACHROCIDIN offers early, potent therapy against such disabling complications as otitis media, sinusitis, bronchitis to which the patient may be highly vulnerable at this time.

Included in the comprehensive ACHROCIDIN formulation are the analgesic components recommended for prompt relief of common cold symptoms.

Adult dosage for ACHROCIDIN Tablets and new, caffeine-free ACHROCIDIN Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children according to weight and age.

Available on Prescription Only

Each tablet contains:

ACHROMYCIN®		Caffeine	30 mg.
Tetracycline	125 mg.	Salicylamide	150 mg.
Phenacetin	120 mg.	Chlorothen Citrate	25 mg.

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*Trademark

NEWS NOTES—from State and Nation

Annual Heart Symposium Scheduled for February 14

Indiana physicians are invited to attend the annual postgraduate symposium on heart which will be held Thursday, February 14, at the Indiana University Medical Center Auditorium.

The symposium is sponsored cooperatively by the Indiana University School of Medicine and the Indiana Heart Foundation.

The afternoon program from 3 to 5 o'clock will feature progress reports on a number of heart research projects supported by the Heart Foundation. Speakers will include Dr. Harold King, instructor; Dr. Harris B. Shumacker, chairman, department of surgery; Dr. Walter E. Judson, associate professor, department of medicine, and Dr. Roy Behnke, assistant professor, department of medicine, all of Indiana University School of Medicine, and Dr. Charles Fisch, director, Robert M. Moore Heart Clinic; Dr. J. Paul Shields, and Dr. Sheldon Pinsky, Krannert Fellows, Robert M. Moore Heart Clinic.

The evening program, beginning at 7:30 o'clock, will feature a panel on rehabilitation of the cardiac with emphasis on myocardial infarction. Dr. Fisch will be moderator while panel members will include Dr. Judson; Dr. Frederick A. Whitehouse, American Heart Association rehabilitation director; Dr. James D. Peirce, director of industrial medicine, Eli Lilly and Company, and Dr. A. Carlton Ernstene, chief of staff, Division of Medicine, Cleveland Clinic.

The Regional meeting of District V of the American College of Obstetricians and Gynecologists will be held Saturday, March 2, in the Netherland Plaza Hotel, Cincinnati. Dr. A. G. King, 199 William Howard Taft Road, Cincinnati 19, Ohio, is chairman.

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Average per capita incidence of suits
1937-1946 58% lower than 1927-1936
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Established 1901—Incorporated
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FRANK B. NORBURY, M.D., Physician

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Maplecrest—

Restful, congenial homelike surroundings are combined with the most modern diagnostic and therapeutic equipment.

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Most comfortable home for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.

Medihaler

Means self-powered, uniform, measured-dose inhalation therapy . . . made possible by specially designed metered-dose valve . . .

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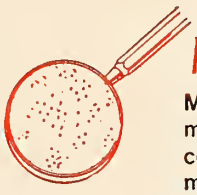
Means notably safe and effective therapy when indicated for children. Medication is in leak-proof plastic coated bottles . . .



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Means true nebulization. Each measured dose provides 80 per cent of its particles in the optimal size range—0.5 to 4 microns radius—insuring effective penetration of the respiratory tract.

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Medication and Adapter fit into neat plastic case, convenient for pocket or purse . . .

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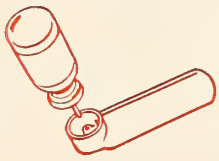
Means an unbreakable Oral Adapter—no movable parts—no glass to break—no rubber to deteriorate . . .



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Means greater economy—no costly glass nebulizers to replace, and one or two inhalations usually suffices for prompt relief.

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The Unique Measured-Dose Inhalation Method

In Asthma

For Rapid Relief of Acute or Continuing Bronchospasm

Medihaler-Epi®

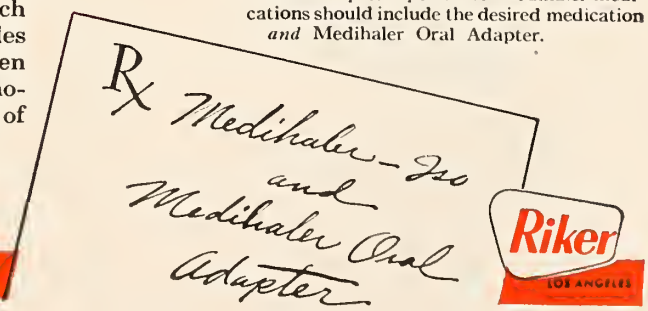
Riker brand of epinephrine 0.5% solution in inert, nontoxic aerosol vehicle. Each ejection delivers 0.125 mg. epinephrine. In 10 cc. vial with metered-dose valve, sufficient for 200 inhalations.

Medihaler-Epi replaces injected epinephrine in emergency situations in which respirations have not ceased. It provides rapid relief in acute food, drug, or pollen reactions (including urticaria, bronchospasm, angioneurotic edema, edema of glottis, etc.). In most instances only one inhalation is necessary.

Medihaler-Iso®

Riker brand of isoproterenol HCl 0.25% solution in inert, nontoxic aerosol vehicle. Each ejection delivers 0.06 mg. isoproterenol. In 10 cc. vial with metered-dose valve, sufficient for 200 inhalations.

Note: First prescription for Medihaler medications should include the desired medication *and* Medihaler Oral Adapter.



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. . . a non-profit, humanitarian organization with a goal of leadership in research, training, and facilities for the treatment of neuropsychiatric disorders.

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Indiana Medical School Graduate Joins Upjohn Medical Staff

Dr. Hubert C. Peltier, who received his degree in medicine from Indiana University School of Medicine in 1948, has joined the Medical Division of The Upjohn Company at Kalamazoo. Dr. Peltier, who attended both Manhattan College and Indiana University, is a pediatrician.

Contract renewals granted recently by the U. S. Atomic Energy Commission to 92 universities and private institutions for research projects in the atomic energy field included two to the Indiana University Foundation. A grant of $22,500 was made for research on "The Influence of Radiation in Altering the Incidence of Mutations in Drosophila" by H. J. Muller. A grant of $7,000 was made for the study on "Energy Transport in Bacterial Cell-Free Extracts" by Roy Repaske.

AMA Approval Announced for Army's General Practice Residency

Approval of the two-year residency program in general practice at the U. S. Army Hospital, Fort Knox, Kentucky, has been given by the Council on Medical Education, American Medical Association, according to information received by the Education and Training Division, Office of The Surgeon General of the Army.

This is the only residency program of general practice conducted by the Army Medical Service and has 16 participants. The first year of the program is devoted to medicine and medical sub-specialties, including six months in pediatrics; the second, to surgery and surgical subspecialties, including six months in gynecology and obstetrics.

The next scheduled examinations (Part II) oral and clinical for all candidates for certification by the **American Board of Obstetrics and Gynecology** will be conducted at the Edgewater Beach Hotel, Chicago, by the entire board from May 16 through May 25. Formal notice of the exact time of each candidate's examination will

relaxes both mind and muscle

for the average patient in everyday practice

- well suited for prolonged therapy
- well tolerated, nonaddictive, essentially nontoxic
- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness
- chemically unrelated to chlorpromazine or reserpine
- does not produce significant depression
- orally effective within 30 minutes for a period of 6 hours

Indications: **anxiety and tension states, muscle spasm.**

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Tranquilizer with muscle-relaxant action

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2-methyl-2-n-propyl-1,3-propanediol dicarbamate—U.S. Patent 2,724,720

SUPPLIED: *400 mg. scored tablets. Usual dose: 1 or 2 tablets t.i.d.*

Literature and Samples Available on Request

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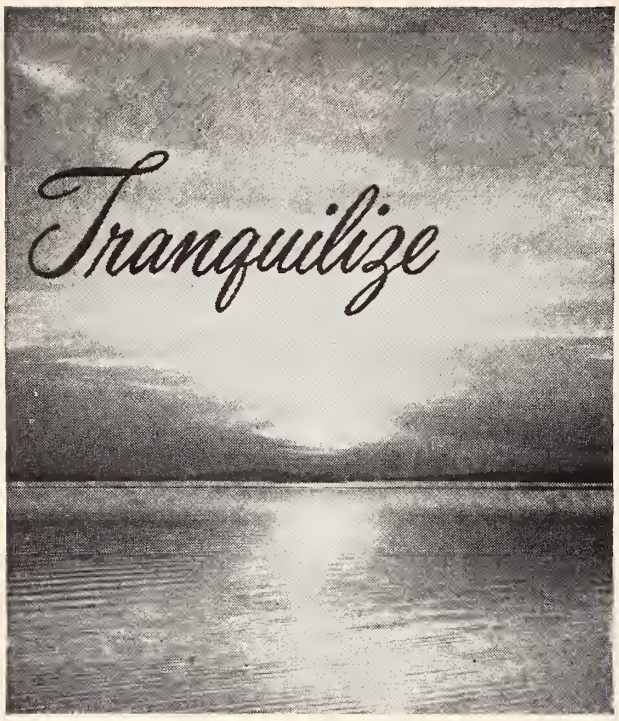

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- Soothes the central nervous system, produces calmness without hypnosis.
- Non-toxic, non-cumulative, non-addicting, no known contraindications.
- Does not impair mental or physical function.
- Orally effective within 30 minutes for sustained action up to 6 hours.
- Economical.

Indications: Tension, nervousness, anxiety and muscular spasm.

Supplied: White round tablets Acetylcarbromal 5 gr. in bottles of 100, 1000.

Write for samples and literature

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MALLARD, INC.

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be sent him in advance. Candidates who participated in Part I examinations will be notified of their eligibility for Part II examinations soon.

Dr. Arlie Ray Barnes, Jennings county native and graduate of Indiana University School of Medicine, who now is professor of medicine at the University of Minnesota, Rochester, received the Gold Heart Award of the American Heart Association at the annual meeting of that organization.

Gen. Mark Clark, former resident of Indianapolis and now president of The Citadel, South Carolina military college, received a similar award. Presentations were made by Dr. Irvine H. Page, Cleveland, who is also a native of Indiana. James A. Stuart, president of the Indiana Heart Foundation and editor of the *Indianapolis Star,* serves on two AHA committees.

Dr. C. J. Maternowski, who has been in general practice in Valparaiso for two years, is serving a 3-year internal medicine residency at the University Hospitals, Ann Arbor, Michigan. Dr. Maternowski is a native of South Bend, where he took his premedical training at Notre Dame University. He received his medical degree from St. Louis University School of Medicine.

Dr. Glen A. Ramsdell, Richmond physician, has been named medical director of Smith-Estep Tuberculosis Hospital. Mrs. James Mulberry, also of Richmond, has been named nursing director of the hospital. Dr. Ramsdell, who will retain his private practice, and Mrs. Mulberry have taken charge of the hospital where a vacancy was created by the resignation of Dr. James Kaler, who had served as superintendent.

Dr. James N. Hampton, who has been in practice in Hillman, Michigan, opened an office at 121 East Walnut Street in Argos December 10, for the general practice of medicine. He and Mrs. Hampton and their three children are now residing in Argos.

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integrated relief . . .
mild sedation
visceral spasmolysis
mucosal analgesia

TABLETS *(yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.*

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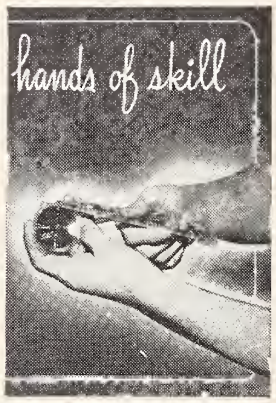

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OPTICAL COMPANY

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GENERAL OFFICES: COLUMBUS 16, OHIO

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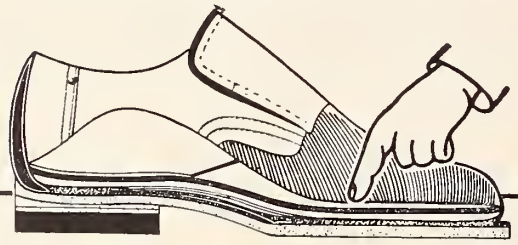
Insoles do not crack or curl from perspiration★



- Insole extension and wedge at inner corner of heel where support is most needed.
- The patented arch support construction is guaranteed not to break down.
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- Foot-so-Port lasts designed and the shoe construction engineered with orthopedic advice.
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Dr. D. D. Gill, who has been in general practice in Greenfield, spent the month of January in Chicago, where he took special training under Dr. Philip Thorek. On completion of that work, Dr. Gill was to go to Boston, where he planned a two months residency at Lahey Clinic, where he was to take special training in pediatric surgery and surgery of the newborn. About April 1 Dr. Gill plans to return to Greenfield where he will specialize in surgery.

Dr. J. J. Farrell, Jr., who has been associated with Dr. Gill in general practice for more than a year, will continue to maintain their office.

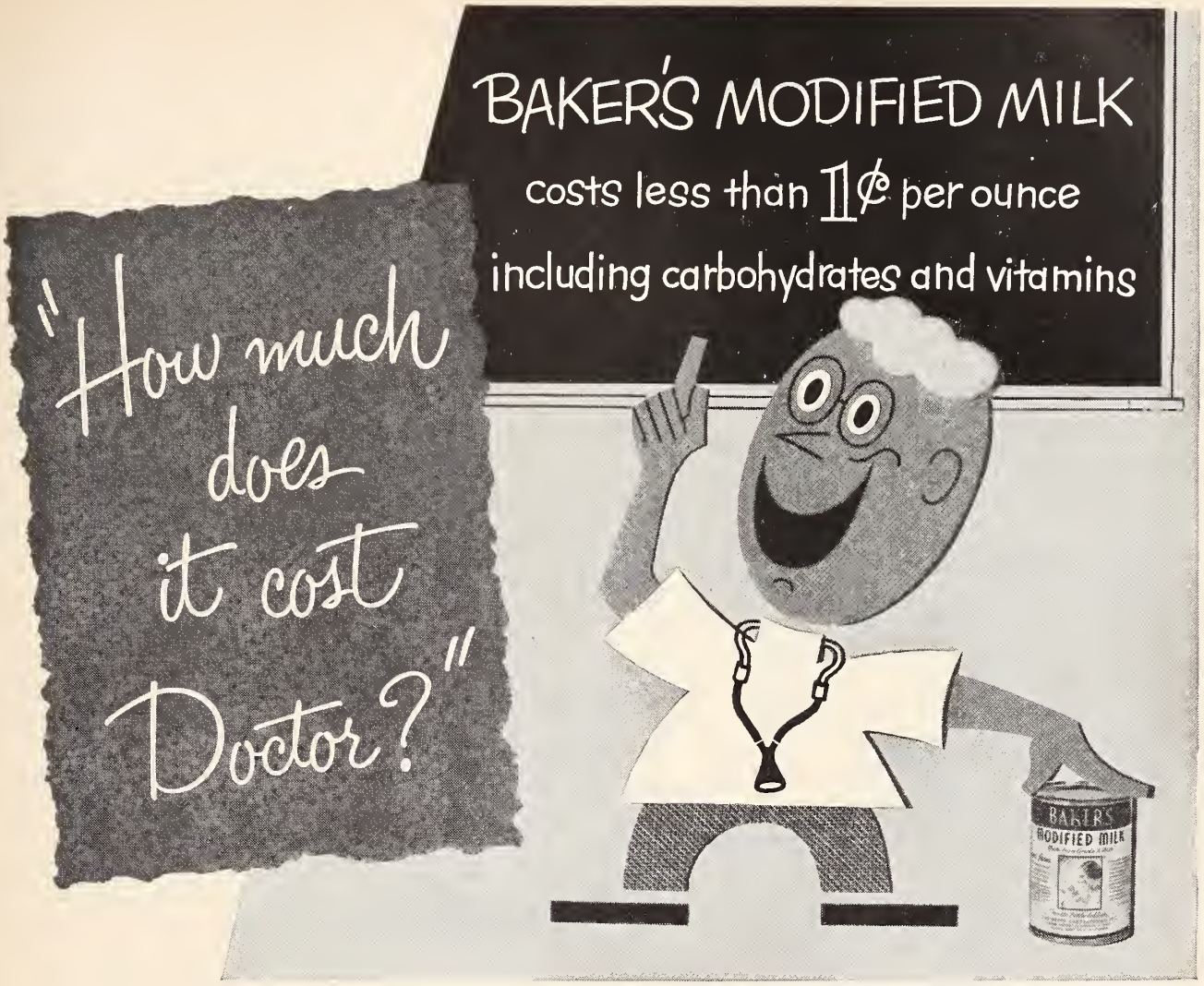
Long Tenure in Office to Be Broken at End of Term

Dr. M. B. Stewart, Logansport physician for many years, was recently sworn into office as Cass County coroner. He has served for 36 years and will be unable to serve again until he has skipped four years, a provision of a recent state law which prevents serving more than 8 years out of a 12-year period. Dr. Stewart first served as coroner in 1918.

Drs. William R. Shaffer, James C. Miller and **Robert P. Acher** recently presented a panel discussion on heart disease to the Greensburg Kiwanis Club. With the use of a blackboard diagram, Dr. Acher outlined the structure and function of a normal heart. The three physicians presented different phases of heart disease and damage resulting from other diseases.

Dr. Noel S. Graves, Vevay, has been named Switzerland county health officer to fill the unexpired term of Dr. L. H. Bear. Dr. Graves is a native of Muncie, graduate of I.U. School of Medicine, and has practiced in Vevay since 1950.

Dr. G. H. Wilson, Bicknell, is serving as deputy coroner for Knox county and will handle coroner's cases for the northern section of the county. He was appointed to the post by George D. Gardner, Vincennes, who became coroner January 1.



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Prescribe Baker's Modified Milk in the hospital and thus provide mothers with an economical, complete infant formula.

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PHENAPHEN® PLUS

MISERABLE COLD

each coated tablet:

Phenacetin (3 gr.)	194.0 mg.
Acetylsalicylic Acid (2½ gr.)	162.0 mg.
Phenobarbital (¼ gr.)	16.2 mg.
Hyoscyamine Sulfate	0.031 mg.
Prophenpyridamine Maleate	12.5 mg.
Phenylephrine Hydrochloride	10.0 mg.

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today's health a must!

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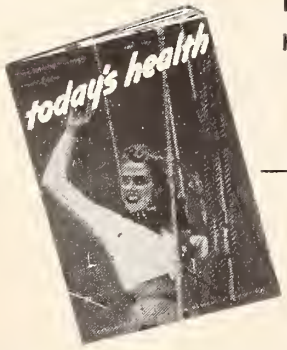
Physicians' Half-Price Rates



4 years	$4.00
3 years	3.25
1 year	1.50

AMERICAN MEDICAL ASSOCIATION
535 North Dearborn · Chicago 10, Illinois

Industrial Nurses Name Medical Advisory Council

Two advisory councils, one representing management and the other the medical profession, have been named by the Indiana Association of Industrial Nurses, Inc., an affiliate of the American Association of Industrial Nurses since September 28, 1956.

Elected to the Medical Advisory Council for two years were: Dr. Emmett B. Lamb, Indianapolis, chairman; Dr. Louis W. Spolyar, Indianapolis; Dr. H. Glenn Gardiner, East Chicago; and Dr. E. S. Jones, Hammond.

Other members who will serve for one year are: Dr. F. Minton Hartz, Evansville; Dr. H. W. Garton, Fort Wayne; and Dr. M. D. Wygant, Mishawaka.

Grants for hospital construction in Indiana under the Hill-Burton Act, reported November 30 by the Department of Health, Education and Welfare in Washington, now total $16,335,948. That is the federal government's contribution toward projects costing $44,373,127 designed to supply 2,201 additional hospital beds in the state. Nine projects are under construction; three have been completed, and no new projects had been approved at the time of the report.

Dr. Joseph E. Hance, formerly of Oxford, Ohio, is now associated with Doctors' Hospital, Michigan City, where he will be in general practice. Dr. Hance is a graduate of the University of Cincinnati School of Medicine, served in the U. S. Air Force, and practiced in Oxford for two years before coming to Indiana. He is married and has one child. Dr. and Mrs. Hance live at 601 Highland Avenue, Michigan City.

Dr. Wilbur Pierce Hicks, a 1949 graduate of Indiana University School of Medicine, has established a general surgery practice in the offices of Dr. Frank P. Lloyd, 1540 Columbia Avenue, Indianapolis. Dr. Hicks served during the Korean war and on his return was chief of obstetrics and gynecology at Fort Benjamin Harrison Army Hospital. He was discharged as a major. Dr. Hicks served in the Army Medical Corps during 1955 and 1956.

Many of your patients, Doctor, are among the millions of people who have seen this newest Parke-Davis advertisement on the cost of today's more effective medical care. We believe that this sensible-talking ad —the latest in a continuing P-D series appearing in LIFE, TIME, SATURDAY EVENING POST and TODAY'S HEALTH—dramatically confirms our year-long public service message to your patients: *"prompt and proper medical care may well turn out to be one of the biggest bargains of your life."*

You may be assured that Parke-Davis national advertising will continue to be in our mutual best interests . . . designed to give your patients a better understanding of costs and a clearer appreciation of the effectiveness of modern medical care. PARKE, DAVIS & COMPANY, Detroit 32, Michigan.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

December 12, 1956

Roll call showed the following present: James W. Denny, M.D., chairman; E. H. Clauser, M.D.; Elton R. Clarke, M.D.; M. C. Topping, M.D.; Wemple Dodds, M.D.; O. W. Sicks, M.D.

Albert Stump and Robert Hollowell, attorneys; R. J. Amick and K. W. Bush, field secretaries; James A. Waggener, executive secretary.

Membership Report:

Number of members December 12, 1956 ____ 4,045*
Number of members December 12, 1955 ____ 3,943
Gain over last year _____ 102
Number of members December 31, 1955 ____ 3,975

* Includes 92 in military service (gratis)
149—$10 members (residents and interns)
288—senior members
74—members, dues remitted by Council
2—honorary members

Number who have paid AMA dues:
December, 1956 _____ 3,857**
December, 1955 _____ 3,760
Gain _____ 97

** Includes 628 exempt members (gratis)
393 prior to 1/1/56
248 so far this year

173 1956 ISMA members are delinquent in payment of 1956 AMA dues.

In discussing the membership report the Executive Committee instructed the secretary to refer to the Committee on Constitution and Bylaws their recommendation that said committee study the advisability of changing the Constitution and Bylaws of the Association to require membership in the American Medical Association as well as in the state medical association.

Headquarters Office

Mr. Bush and Mr. Amick reported that they had covered every county medical society in their respective districts during the past two weeks for the purpose of explaining Medicare to the component society members. They spoke very highly of the cooperation given by the officers and members of the various societies who had attended these special meetings.

Statements of Receipts and Expenditures for October and November for the Association and THE JOURNAL were approved.

Annual Convention, French Lick, October 6-9, 1957

The secretary reported on the recommendation of the Committee on Conference of County Medical Society Officers in which it was recommended that the annual county medical society officers' conference be discontinued in 1957 and that it be replaced by an indoctrination program for all new members of the Association, to be held at the time of the annual convention. Upon motion of Drs. Clarke and Topping the committee is to recommend to the Council that such a program be included in the program of the 1957 convention.

Organization Matters

The secretary read a letter from the Department of Health, Education and Welfare in which he was asked to meet with the officials of the Social Security Division in Baltimore on December 17 for the purpose of discussing the Indiana plan of handling the screening of applicants for cash disability benefits under PL 880. The secretary read the presentation which he proposed to make to the officials and on motion of Drs. Topping and Clarke the proposal was approved as drafted.

The secretary also reported that the Indiana delegates had introduced resolution No. 25 before the House of Delegates of the A.M.A. at the Seattle meeting, the resolution carrying out the recommendation that the A.M.A. work for the establishment of such screening committees. The resolution was adopted as presented and referred to the Board of Trustees for study and implementation.

A letter from the A.M.A. was read in which they were asking the states to establish a program in which a key person in each county society would be responsible for the receipt and dissemination of legislative information.

Request of the Methodist Hospital School of Nursing in Gary, in which they sought permission to use the tape recordings from the loan library, was read, and upon motion of Drs. Clarke and Clauser it was voted to make the scientific tapes available to accredited schools of nursing.

The secretary reported in detail the actions taken by the A.M.A. House of Delegates during the Seattle meeting.

The Journal

Report on advertising was approved by consent:

			Net gain
Total, Oct., 1956	$4,292.25		
Total, Oct., 1955	4,273.48	Oct.	$ 18.77
Total, Nov., 1956	$4,762.45		
Total, Nov., 1955	3,917.91	Nov.	$ 844.54
Total, Dec., 1956	$3,781.99		
Total, Dec., 1955	2,471.19	Dec.	$1,310.80

A letter from Mr. Stump concerning a proposed publication of the Legal Department of the A.M.A. was read in which Mr. Stump raised certain objections to the contents of the publication. By consent

it was agreed that Mr. Stump should write another letter to the American Medical Association objecting to the method in which the book was prepared and questioning the advisability of the A.M.A. issuing such a book.

Medicare. Communication dated November 27, known as Modification No. 1 of the Dependents' Medical Care Contract, was reviewed in which they proposed certain amendments in the contract. Upon motion of Drs. Topping and Clauser the changes were approved and the president authorized to sign.

A letter from the Blue Shield Board, addressed to Dr. J. W. Denny, chairman of the Executive Committee, was read in which they notified the Association they would refuse to pay any claim authorized for payment by the Association under the Medicare program which exceeded the average schedule of fees which had been submitted.

The secretary reported on his discussion with Mr. Hassard of San Francisco, attorney for the Blue Shield Plans, in which he claimed Blue Shield had no financial liability under the contract.

Upon motion of Drs. Clauser and Clarke, Mr. Hollowell was instructed to follow his own suggestions to write a letter to the Government for interpretation of the contract in existence between the Government, Blue Shield, and the Association.

The secretary reported that claim forms had been received and that the Government is requiring them to be completed in triplicate.

The secretary reported that one of the field secretaries had called his attention to a bulletin which has been circulated by the American Hospital Association, known as Bulletin No. 2, dated November 28, in which the Hospital Association was advising its member hospitals that in cases where a doctor admitted a dependent under the Medicare program to the hospital as an outpatient that the hospital should bill the doctor for the hospital charges and then let the doctor collect from the Government. The secretary reported that he had called this to the attention of the American Medical Association and that they were making an immediate investigation of the contents and intent of this statement.

The request of the Woman's Auxiliary for a joint meeting with the Executive Committee was considered and the secretary was instructed to notify the Auxiliary that they would meet with them at 6:30 p.m., January 19, 1957, at the Student Union Building.

There being no further business the Committee adjourned to meet again at 5:00 p.m., Saturday, January 19, 1957, in the Student Union Building, Indiana University Medical Center.

District Meeting Reports

THIRTEENTH COUNCILOR DISTRICT

Four lectures on new medical techniques and drugs were presented at the annual meeting of the Thirteenth District Medical Society which was held in the Hotel Elkhart, Elkhart, November 14.

"Tranquilizers and Other New and Abused Drugs" was the subject of the paper presented by Dr. S. H. Frazier, division of psychiatry, Mayo Clinic, Rochester, Minnesota. The speaker said the tranquilizers offer great hope to the psychiatrist but cannot be considered a cure for mental disturbances. "These drugs will not empty mental hospitals, they merely make them pleasanter places to be," he told his audience of approximately 50 northern Indiana physicians. Used in this way he said the cost of the drugs was more than offset by the savings on hospital property, replacement of which was formerly a tremendous budget item. The subject of the oral treatments for diabetes was discussed at length by Dr. Stefan S. Fajans, assistant professor of internal medicine at the University of Michigan, Ann Arbor. Side effects of these drugs complicate their use, the speaker said.

Other scientific speakers were Dr. Fred Shapiro, clinical assistant professor of orthopedic surgery at Presbyterian Hospital, Chicago, who discussed "Principles and Technique of Closed Method of Fractures of the Leg," and Dr. William S. Kroger, associate professor of gynecology, Chicago Medical School, who talked on "Hypnosis in Obstetrics."

Other speakers during the afternoon and evening program were Dr. Elton R. Clarke, Kokomo, president of ISMA, who praised the district for its high quality practice and interest in medical organization; James A. Waggener, executive secretary of ISMA, who outlined provisions of the Medicare plan for dependents of military personnel; and Dr. Russell B. Roth, Erie, Pennsylvania, the after-dinner speaker, who spoke on "Medical P-R Picture, Oblique View."

Attendance at the district luncheon was reported as 26; the Auxiliary luncheon attendance was 56; and the evening banquet was enjoyed by 89 physicians and their wives.

Dr. G. O. Larson, LaPorte, was named councilor for a three-year period; and Dr. B. A. Biasini was named alternate councilor to complete Dr. Larson's term.

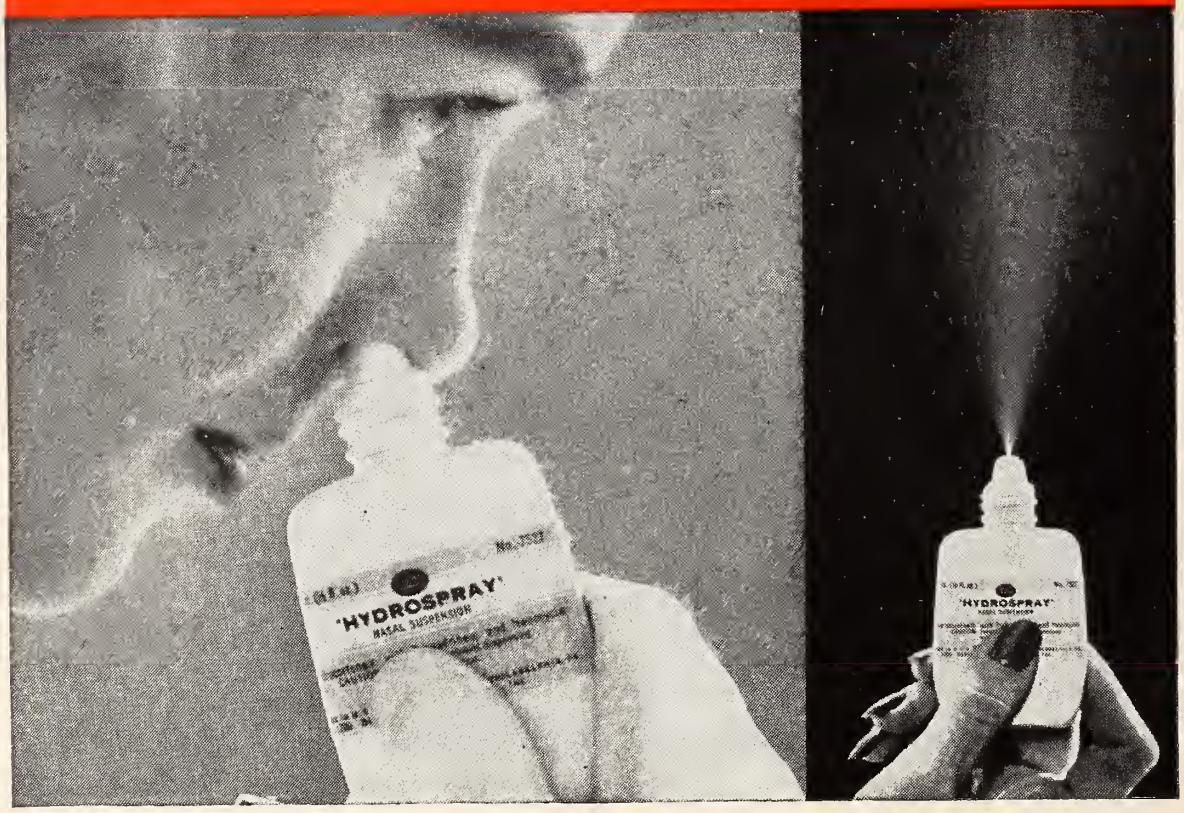
New president of the 13th District Medical Society is Dr. R. E. Nelson, South Bend; vice-president is R. L. Bender, Elkhart, and Dr. O. E. Wilson, Elkhart, was reelected secretary-treasurer for the twelfth year. The 1957 meeting will be held on November 20 in South Bend.

'Hydrospray' NASAL SUSPENSION

(HYDROCORTONE® WITH PROPADRINE® AND NEOMYCIN)

Anti-inflammatory—Decongestant—Antibacterial

MAJOR ADVANTAGES: New synergistic anti-inflammatory, decongestant and antibacterial formula. High steroid content assures effective response.



Topically applied hydrocortisone[1] in therapeutic concentrations has been shown to afford a significant degree of subjective and objective improvement in a high percentage of patients suffering from various types of rhinitis. HYDROSPRAY provides HYDROCORTONE in a concentration of 0.1% plus a safe but potent decongestant, PROPADRINE, and a wide-spectrum antibiotic, Neomycin, with low sensitization potential. This combination provides a three-fold attack on the physiologic and pathologic manifestations of nasal allergies which results in a degree of relief that is often greater and achieved faster than when any one of these agents is employed alone.
INDICATIONS: Acute and chronic rhinitis, vasomotor rhinitis, perennial rhinitis and polyposis.

SUPPLIED: In squeezable plastic spray bottles containing 15 cc. HYDROSPRAY, each cc. supplying 1 mg. of HYDROCORTONE, 15 mg. of PROPADRINE Hydrochloride and 5 mg. of Neomycin Sulfate (equivalent to 8.5 mg. of neomycin base).

MSD

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

REFERENCE: 1. Silcox, L. E., *A.M.A. Arch. Otolaryng.* 60:431, Oct. 1954.

News from the County Societies

Members of the Lutheran Hospital staff presented the scientific program for the January 8 meeting of **Fort Wayne (Allen County) Medical Society** in the Chamber of Commerce.

"Convulsive Disorders of Children" was the topic discussed by Drs. Warren Hastings, Wallace Bash and Ernest R. Carlo. Dr. H. Vaughn Scott served as moderator. Dr. Hastings discussed the neurophysiology and pathology of the convulsive disorder; Dr. Bash talked on diagnosis and differential diagnosis; and Dr. Carlo, therapy of the convulsive disorder.

A general business meeting followed the scientific program.

Thirty members of **Bartholomew-Brown County Medical Society** attended the annual meeting December 12 in Palms Cafe, Columbus. Reports of committees and activities were presented followed by election of officers. Dr. David Adler, Columbus, was named president; Dr. W. J. Ryan, Columbus, vice-president; and Dr. Alvin Henry, also of Columbus, secretary-treasurer.

At the January 9 meeting of the society, Dr. George Parker, Indianapolis, spoke on "The Rh Problem." Twenty-seven members were present for the dinner meeting in Palms Cafe, Columbus.

An evening meeting of **Boone County Medical Society** was held in Witham Memorial Hospital, Lebanon, January 8 with 12 members attending. Dr. C. G. Kern reported on the County Medical Society Officers Conference of ISMA. Dr. H. B. Grigsby, Lebanon, was voted into the society as a new member.

Carroll County Medical Society members elected officers for 1957, reaffirmed their stand favoring fluoridation of water, recommended that all persons up to 40 years of age have polio vaccine shots, and discussed first aid measures for schools in case of accidents or acute illness, at the meeting held December 12 in the Roth Park Hotel.

Officers who will serve during 1957 are Dr. T. Neal Petry, Delphi, president; Dr. George Wagoner, Delphi, vice-president; and Dr. C. L. Wise, Camden, secretary-treasurer. Dr. Robert Seese, Delphi, was named delegate to ISMA, and Dr. Wise will serve as alternate delegate.

Eight members and three guests attended the meeting.

Thirty-five members of the **Delaware-Blackford County Medical Society** held a dinner meeting in the Roberts Hotel, Muncie, on January 8. No scientific program was planned. A general business meeting was held.

New officers of the society are: Drs. Anson G. Hurley, Muncie, president; F. E. Stout, Muncie, vice-president; I. S. Hostetter, Muncie, secretary; and Philip Ball, treasurer. Delegates to the Indiana State Medical Association are Drs. R. M. Butterfield, Muncie; T. M. Brown, Muncie; and W. T. Douglas, Montpelier. Alternates are Drs. G. E. McCoy, Muncie; Tom Botkin, Muncie; and Paul Burns, Montpelier.

Dubois County Medical Society members admitted three new members and reinstated a former member who had returned from military service at a luncheon meeting held in Jasper on December 12. New members are Drs. John Beaven and Paul Singer of Jasper, and Elton Heaton of Huntingburg. Dr. J. P. Salb was reinstated after serving in the Air Corps medical service.

Officers elected for 1957 are Dr. Arthur Wagner, Jasper, president; Edward J. Ploetner, Jasper, president-elect; and Elton Heaton, Huntingburg, secretary-treasurer. Dr. Salb was named delegate to ISMA and Dr. Ploetner, alternate. Fifteen members attended the meeting.

"Medicine's Trojan Horse" was the subject of a talk given by Dr. James L. Doenges, Anderson, in the Connersville Country Club before 17 members of the **Fayette-Franklin County Medical Society** on December 11.

At the election of officers held following dinner Dr. W. A. Kemp, Connersville, was named president; Dr. H. N. Smith, Brookville, vice-

Perry County Medical Society members are pictured here at a fall meeting. Upper photograph shows Dr. Fred Smith Jr., now president of the society, Dr. H. S. Dome, and Dr. L. C. Lohoff, secretary. Center, Drs. E. R. Snyder and John M. James. Drs. H. R. Bush and N. A. James are seen in lower picture.

president; and Dr. Joseph L. Steinem, Connersville, reelected secretary-treasurer. Dr. Bertram Sanders, Connersville, was elected delegate to ISMA from Fayette county, and Dr. Smith selected as the delegate from Franklin county. Alternate delegates are Dr. A. F. Gregg, Connersville, and Michael Truman, Brookville.

On January 8 the society had two speakers at their dinner meeting in the Connersville Country Club. Dr. C. L. Poston, Laurel radiologist, discussed "Unusual X-Ray Lesions," and Robert J. Amick, ISMA field secretary, talked on the legislative bulletins which are to be furnished each county society secretary during the 1957 session of the Indiana General Assembly. Daily bulletins will be mailed each county to keep members informed on proposed legislation.

Dr. and Mrs. John Fisher were hosts for the January 3 meeting of the **Fountain-Warren County Medical Society** in their home in Attica. Eleven members, their wives and two special guests, Dr. and Mrs. Harold W. Keschner, Danville, Illinois, were present.

At a short business meeting held before dinner, officers for 1957 were elected. Dr. Carl A. Nelson, West Lebanon, will serve the society as president; Dr. Peter R. Petrich, Attica, is vice-president; and Dr. Lowell R. Stephens, Covington, secretary-treasurer. Delegates to the state convention are Drs. Lee J. Maris, Attica, and James W. Crain, Williamsport. Alternate delegates are Dr. Stephens and Dr. Nelson. Dr. Stephens was also elected to a three year term on the board of censors.

Dr. H. C. Sprecher, Evansville, presented a paper on "Ano-Rectal Diseases and Treatment" to 10 members and 7 guests of **Gibson County Medical Society** at the January 9 meeting in the Emerson Hotel, Princeton.

Hancock County Medical Society members entertained their wives and several special guests at their annual Christmas party in the home of Dr. and Mrs. R. W. Kuhn in Wilkinson. A buffet supper was served to 40 guests.

Dr. Charles Titus of Wilkinson was the special guest of the society and was commended for his 62 years of medical practice and his service to the community and the society.

Dr. Frank D. Hogle, Indianapolis, spoke on "Tranquilizing Drugs" at a meeting of **Howard County Medical Society** held in the Frances Hotel, Kokomo, on January 8.

Thirty-two members and 2 guests attended the dinner meeting and received 1957 committee appointments.

New Howard County officers are Drs. L. D. Denton, Greentown, president; Warren Mc-

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Clure, Kokomo, vice-president; and Stanley M. Mendelson, Kokomo, secretary-treasurer. Dr. Richard P. Good, Kokomo, was named delegate to ISMA, and Dr. Garvey Bowers, Kokomo, the alternate delegate.

A joint meeting of **Jackson** and **Jennings County Medical Societies** was held in Schneck Memorial Hospital in Seymour December 3 for the purpose of hearing a detailed explanation of the Medicare program which was given by R. J. Amick, field secretary for the Indiana State Medical Association.

LaGrange County Medical Society members recently elected Dr. Charles D. Benedict, Lagrange, president for 1957. Other officers serving with him are Drs. L. R. Studebaker, LaGrange, vice-president; K. M. Lehman, Topeka, secretary-treasurer; Philip E. Yunker, Howe, delegate to the Indiana State Medical Association; and J. H. Williams, Shipshewanna, alternate delegate.

Dr. Franklin F. Premuda, Hessville, became president of the **Lake County Medical Society** at the annual installation dinner in Phil Smidt's restaurant, Whiting, on January 5. Dr. Michael Shellhouse, Gary, was named president-elect, and Dr. Leon J. Armalavage, Gary, secretary.

The society's 1956 Oberlin Award for "distinguished lay contribution to the health of the people of Lake County" was presented to the AFL-CIO Lake County Central Labor Union in recognition of its efforts in raising $100,000 for a rehabilitation center to be constructed as a part of a new wing at Gary Methodist Hospital.

The Oberlin Award was established 18 years ago by the Lake County Medical Society upon the death of Dr. Thomas W. Oberlin, one of the county's pioneer medical leaders.

Dr. Edmond Foley, Chicago internist, spoke on "Viral Diseases" at the December 13 dinner meeting of the **LaPorte County Medical Society** in the Golden Sands Restaurant, Michigan City.

The attendance total was 54, including members, their wives and special guests.

Separate meetings of the society and the Auxiliary were held.

Physicians adopted a fee schedule and discussed an educational program to inform the public of the importance of immunization against communicable diseases.

A business meeting of **Lawrence County Medical Society** was held at noon December 5 in Dunn Memorial Hospital, Bedford, with 22 members present. Officers for 1957 were elected; an explanation of the Medicare program was given by R. J. Amick, ISMA field secretary, who also showed a film "The Doubting Doctor." During the business meeting it was also voted to accept a proposed interprofessional code.

Officers elected were Drs. Thomas J. Fountain, Bedford, president; James Oswalt, Mitchell, vice-president; and R. D. Hawkins, Bedford, secretary-treasurer. Dr. Howard T. Hammel, Bedford, was named ISMA delegate; and Dr. William Robinson, Mitchell, alternate. Drs. Joseph Dusard, K. T. Edmonds, and T. J. Fountain, all of Bedford, were named as the board of censors.

At the January 2 meeting of the society in Dunn Hospital, the 17 members attending the luncheon held a routine business meeting during which they approved a local patch testing program.

Madison County Medical Society members met for dinner in the Anderson Country Club on December 17 with 48 physicians present. Dr. Donald H. Ferguson, Anderson, was elected to membership.

Officers named to serve the Madison County Society during 1957 are Drs. Walter J. Aagesen, Anderson, president; James L. Lamey, Anderson, vice-president; and Merrill P. Benoit, Anderson, secretary-treasurer. Drs. P. T. Lamey and Gordon B. Wilder, Anderson, were elected delegates to the Indiana State Medical Association. Drs. S. W. Ellis and J. L. Larmore, Anderson, will serve as alternate delegates during the coming year.

Dr. Harry Pandolfo was named president-elect of **Indianapolis (Marion County) Medical Society** at the annual business meeting held in Methodist Hospital, Indianapolis, on December 11. Others elected were Dr. A. T. Stone, vice-president; Dr. Ottis N. Olvey, secretary-treasurer; Dr. Bernard D. Rosenak, library

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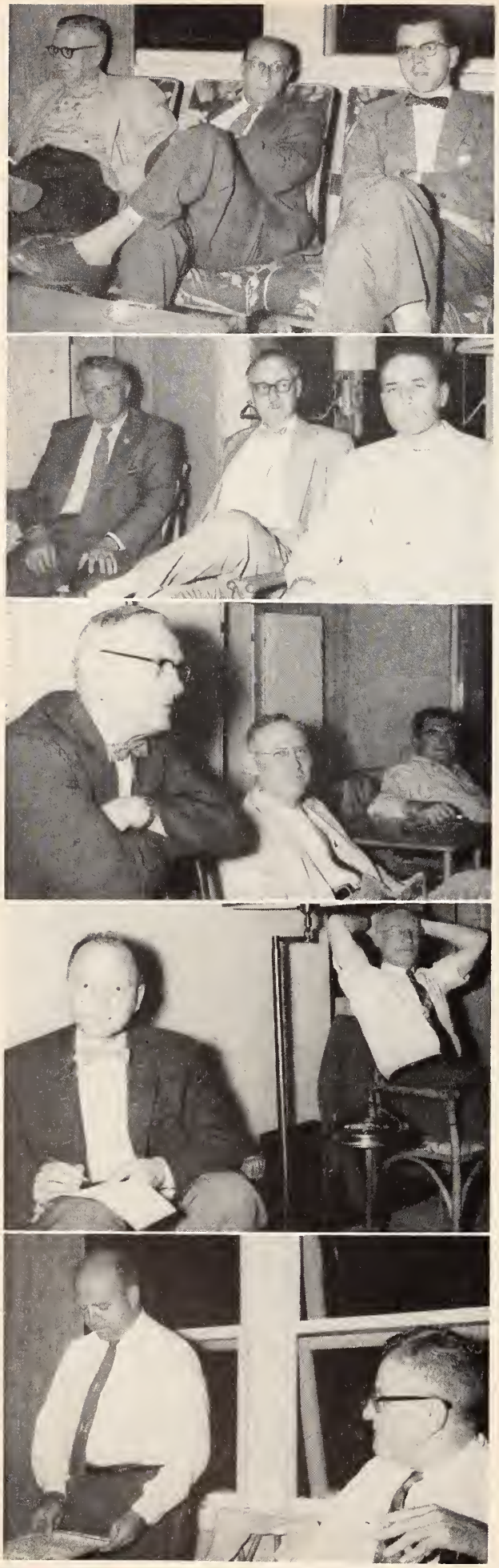

committee; Drs. Irvin Caplin, Albert M. Donato, John W. Hendricks, Louis W. Nie, Myron H. Nourse, Robert D. Pickett and Elsworth K. Stucky for three-year terms on the Council; Drs. Edward F. Bloemker, Ralph V. Everly, Roy A. Geider, John W. Hendricks, Harold C. Ochsner, Lowell I. Thomas and Donald E. Wood for three year terms as delegates; and Drs. John W. Beeler, A. D. Dennison, Albert M. Donato, Francis P. Jones, Robert W. McTurnan, Richard M. Nay, Chester A. Stayton, Jr., and Hugh K. Thatcher, Jr., as alternate delegates for three-year terms.

Ten new members were elected following approval by the Council. They are Drs. Merle S. Bacastow, transfer from Worcester, Massachusetts; John D. VanNuys, James Booze, William L. Gregory, James Jay, Frank B. Throop, Wendell Edwards, James R. Doty, Jr., Donald L. Foxworthy and Peter P. Szumilas.

At the conclusion of the January 8 meeting of the society, which was held in the Empire Life Auditorium, Dr. James M. Leffel assumed the presidency and delivered an address entitled "Give Medicine Back to the Doctors."

Dr. Ralph V. Everly, 1956 president, conducted the business meeting when two physicians, Drs. Richard T. Nolin and Ladson L. DuBose, were elected to membership; resolutions memorializing Dr. E. S. Waymire and Dr. Joseph H. Ward were read; and announcement was made of plans for the January 22 meeting when Dr. Frank Gerbode of Stanford University was to be the guest speaker.

At the December 5 meeting of **Marshall County Medical Society** Kenneth W. Bush,

---

Shelby county physicians are shown, left, at a recent meeting of Shelby County Medical Society. Reading from left to right and top to bottom are Drs. Robert D. Spindler, Roger Whitcomb and John O. Alden; John A. Davis, V. B. Scott, and James H. Tower, Jr.; Paul R. Tindall, Rufus M. Nigh, and David B. Silbert; Richard C. Miller and H. H. Inlow; Wilson L. Dalton and Robert W. Gehres.

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ISMA field secretary, was the guest speaker. He presented details of the Medicare program for military dependents. Eleven members of the society met for lunch and a business session in the Warana Restaurant, Plymouth.

Through efforts of the county society a new physician has been secured for Argos and an additional physician for Plymouth, members were informed. The organization is seeking additional doctors for the area.

Marshall county physicians are sponsoring a student nurse's scholarship program for deserving girls interested in entering the field of nursing.

1957 officers of Marshall County Society are Dr. Cecil Burket, Bremen, president; Dr. Robert Reed, Plymouth, vice-president; and Dr. James F. Rimel, Plymouth, secretary-treasurer. Dr. James Kubley, Plymouth, was named delegate, and Dr. A. A. Thompson, Tyner, alternate delegate.

Three Tell City physicians were elected to office in the **Perry County Medical Society** at a meeting January 8 in the Perry County Nursing Center, Cannelton. Dr. Fred Smith, Jr., will serve as president, Dr. P. J. Coultas, vice-president, and Dr. L. C. Lohoff, secretary. Eleven members attended the evening meeting.

A special meeting of the **Spencer County Medical Society** was held December 7 in Cotton's Cafe, Rockport, for the purpose of hearing a detailed explanation of the Medicare plan under which dependents of military personnel may obtain hospital care. Robert J. Amick, ISMA field representative, spoke to the four members present.

Vanderburgh County Medical Society members elected Dr. Patrick J. V. Corcoran, Evansville, president-elect at the annual business meeting and election on December 11 in the Hotel McCurdy, Evansville.

Other new officers are Drs. John Combs, treasurer; Stanton Bryan, Herbert Dieckman and John Visher, board of directors; and Russell Rossow, board of censors.

Dr. Wendell Stover, Boonville, ISMA delegate to the American Medical Association, presented a report of action of the AMA House of Delegates at the Seattle meeting; representatives of the Chamber of Commerce discussed activities of that organization; and a summary of Medicare directives was given by Robert Amick, ISMA field secretary.

At the first 1957 meeting on January 8, Dr. Don Wood, Indianapolis, co-chairman of the Committee on Legislation of ISMA, was the guest speaker. He discussed possible legislation to be considered by the Indiana General Assembly and the attitude of ISMA on various proposals.

The report of Dr. William Daves, 1956 president, was received, and new officers were installed. Dr. Russel Springstun will serve as president in 1957.

At the regular meeting of **Vigo County Medical Society** in the Hotel Deming, Terre Haute, on December 11, the following officers were named for 1957; President, Dr. J. R. Haslem; vice-president, Dr. Wilbert McIntosh; secretary-treasurer, Dr. Hubert T. Goodman (reelected).

Dr. S. R. Combs was elected to the board of censors; Dr. James Richart to the board of trustees; Dr. Norman Silverman, delegate to ISMA; and Dr. W. L. Strecker, alternate delegate.

Wabash County Medical Society met in the Wabash Country Club December 12 for dinner and election of officers. Eleven members attended the meeting.

Dr. Carl J. Elward was named president for the coming year; Dr. Vincent J. Hanneken, vice-president; and Dr. Robert A. Rauh, secretary-treasurer. All three are Wabash physicians.

On January 9 the society held a dinner meeting in the Wabash Cafeteria with 13 members present. During the business session approval was given to recent committee appointments made by the county hospital staff.

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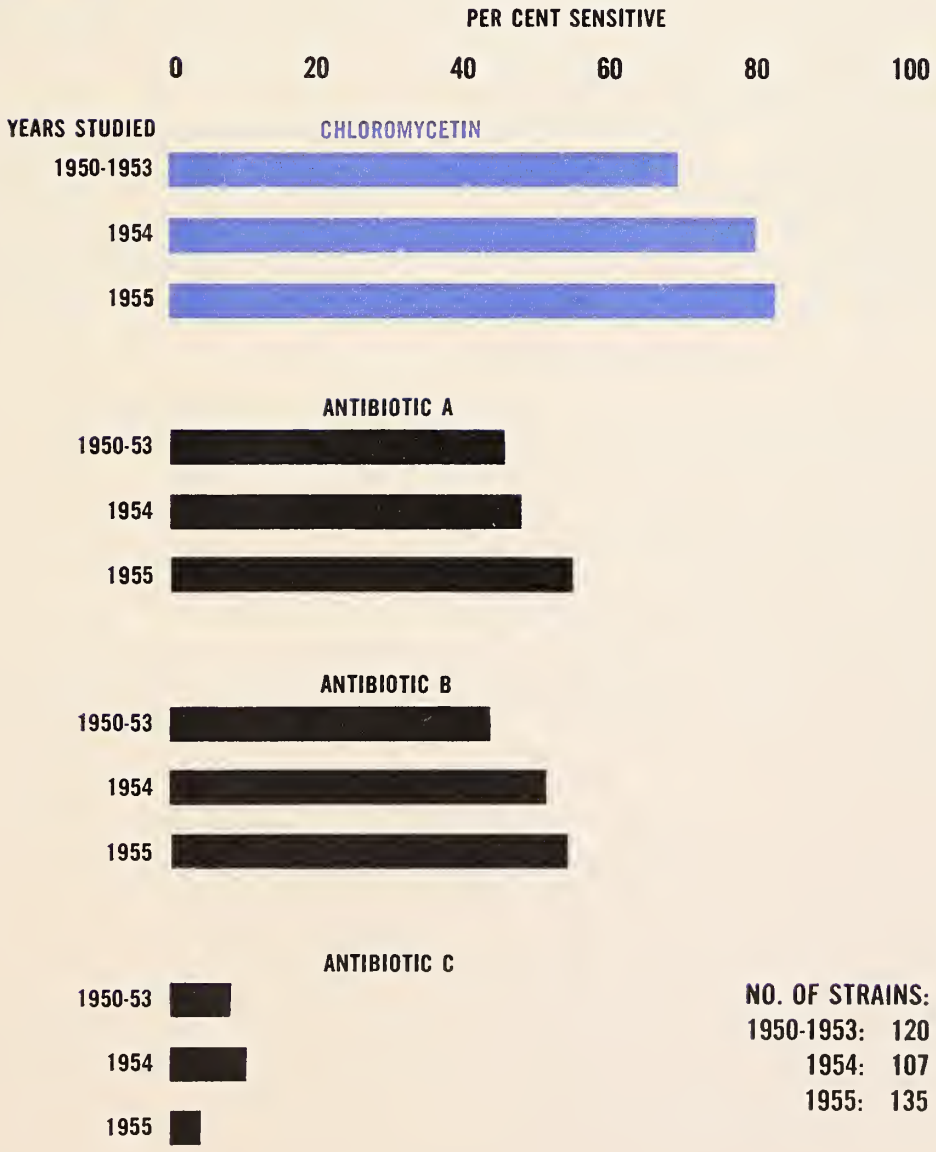

NO. OF STRAINS:
1950-1953: 120
1954: 107
1955: 135

*This graph is adapted from a five-year study by Rantz and Rantz.[n]

The Journal

March 1957

of the INDIANA STATE MEDICAL ASSOCIATION

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All articles must be typewritten, double-spaced, with margins of one inch.

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Only a limited number of illustrations can be used with original articles. The cost of extra illustrations must be borne by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

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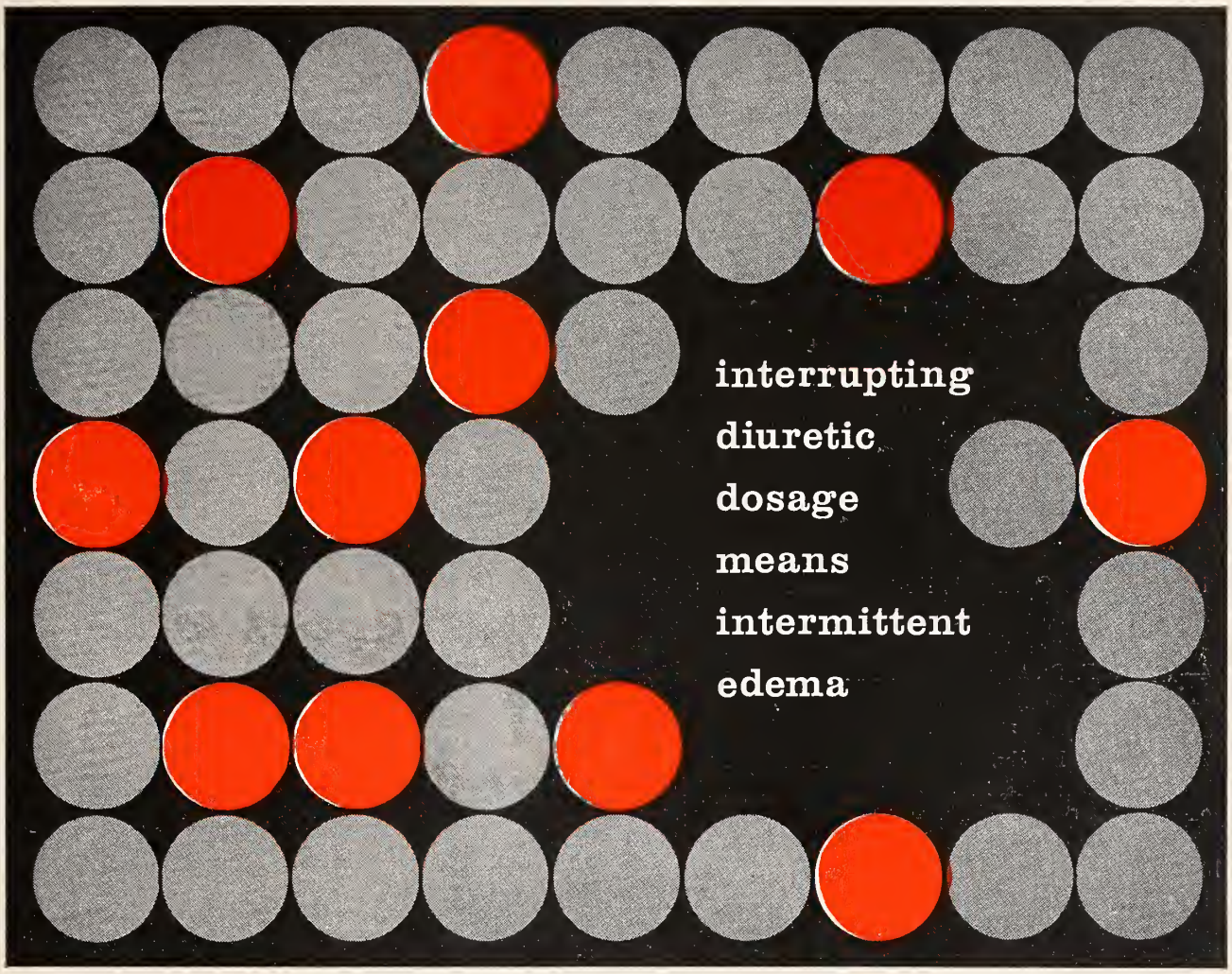

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1	William B. Challman, North Vernon	Dec. 31, 1959
2	J. H. Crowder, Sullivan	Dec. 31, 1957
3	Keith Hammond, Paoli	Dec. 31, 1958
4	Joseph E. Dudding, Hope	Dec. 31, 1959
5	M. C. Topping, Terre Haute	Dec. 31, 1957
6	Harry P. Ross, Richmond	Dec. 31, 1958
7	Ralph V. Everly, Indianapolis	Dec. 31, 1959
8	Guy Owsley, Hartford City	Dec. 31, 1957
9	Wemple Dodds (Chairman), Crawfordsville	Dec. 31, 1958
10	J. P. Vye, Gary	Dec. 31, 1959
11	Max R. Adams, Flora	Dec. 31, 1957
12	Maurice E. Glock, Fort Wayne	Dec. 31, 1958
13	G O. Larson, LaPorte	Dec. 31, 1959

DELEGATES TO THE A.M.A.

Terms expire December 31, 1958:

Delegates	Alternates
Cleon A. Nafe, M.D., Indianapolis	Earl W. Mericle, M.D., Indianapolis
E. S. Jones, M.D., Hammond	William C. Wright, M.D. Fort Wayne

Terms expire December 31, 1957:

Delegates	Alternates
Gordon B. Wilder, M.D., Anderson	Walter L. Portteus, M.D., Franklin
Wendell C. Stover, M.D., Boonville	John M. Paris, M.D., New Albany

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Vice-chairman, Kenneth O. Neumann, M.D., Lafayette.
Secretary, Louis E. How, M.D., South Bend.

1956-57 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	William B. Challman, M.D., Mt. Vernon	William C. Fisher, M.D., Evansville	
2.	Sam I. Rotman, M.D., Jasonville	J. S. Brown, M.D., Carlisle	Linton, June 6, 1957
3.	Wm. H. Robinson, M.D., Mitchell	Joseph C. Dusard, M.D., Bedford	Bedford, May 15, 1957
4.	Winship C. Callaghan, M.D., Greensburg	Robert A. Porter, Westport	Greensburg, May 1, 1957
5.	C. M. Schauwecker, M.D., Greencastle	James B. Johnson, M.D., Greencastle	
6.	Frank H. Green, M.D., Rushville	J. Frank Lewis, M.D., Liberty	Liberty, May 9, 1957
7.	Joseph F. Ferrara, M.D., Franklin	Arthur W. Records, M.D., Franklin	
8.	F. W. McDowell, M.D., Muncie	Clyde G. Botkin, M.D., Muncie	Muncie, June 12, 1957
9.	J. A. Van Kirk, M.D., Frankfort	Dan Tucker Miller, M.D., Fowler	Fowler, May 23, 1957
10.	E. J. DeGrazia, M.D., Valparaiso	Wm. C. Robertson, M.D., Chesterton	May, 1957
11.	T. W. Omstead, M.D., Huntington	Charles L. Wise, M.D., Camden	
12.	C. Jules Heritier, M.D., Columbia City	Floyd B. Kantzer, M.D., Garrett	Pokagon State Park, May 15, 1957
13.	R. E. Nelson, M.D., South Bend	O. E. Wilson, M.D., Elkhart	South Bend, Nov. 20, 1957

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SCIENTIFIC EXHIBITS—A. W. Ratcliffe, chairman (1957); J. L. Arbogast (1957); Jack E. Pilcher (1957); Joseph L. Haymond (1958); Louis C. Bixler (1958); John Spears (1957).

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RURAL HEALTH—Joseph E. Dudding, chairman (1958); John A. Davis, co-chairman (1958); H. N. Smith (1957); Stewart D. Brown (1957); Forrest J. Babb (1957); Richard P. Yoder (1958).

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*Geiger, E.: Digestion, Absorption and Metabolism of Protein, in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, Philadelphia, Lea & Febiger, 1955, pp. 98-143.

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THE MONTH IN WASHINGTON

Washington, D. C.—With Congress now well along in its session, the list of health and medical bills totals several hundred. Some are minor—and few persons will be affected no matter what happens. Others just don't make much sense—and the committees, regardless of politics, can be trusted to let these measures die a peaceful death.

But there are scores of others—all important bills—that have some chance of passage, their prospects ranging from an outside possibility to a strong probability. At this stage they can be regarded as the raw material out of which will come the studies, the debates and the arguments in the months ahead.

One of the major health-medical issues is federal aid to medical, dental and osteopathy schools. On this the administration wants grants for construction and equipment only; some of the Democrats want to include money for operating expenses as well.

GERIATRICS POPULAR TOPIC

In number of bills introduced, the general subject of problems of the aging probably tops the list. And that is no surprise. For several years welfare workers, housing experts and recreational leaders, as well as physicians, have been looking for ways to help the retirement age population. Recently a special center was set up within the Institutes of Health to devote its time exclusively to the aged. Outside government, voluntary groups have also been at work on the same subject.

Now the ideas developed by the years of discussion are coming to the surface in the form of legislation. Several of the bills would set up commissions, appointed either by the President or Congress. Another recommends that an existing House Committee make a study of the aging, similar to that suggested for the various commissions.

The commissions and committees would have one thing in common: They would further study and investigate in a field that many persons believe already has been plowed and replowed by investigators.

Several lawmakers want to get going right away. They would set up within the Department of Health, Education, and Welfare a new Bureau of Older Persons, which immediately would start out to solve some of the problems through grants, demonstrations and more research.

OSCAR EWING'S OLD PROPOSAL

Most controversial of the "help the aged" bills is one originally proposed by the then Social Security Administrator, Oscar Ewing, in 1951. It would allow 60 days a year of government-paid hospitalization every year for persons covered by OASI after they reach age 65. They could have this free service whether or not they were on retirement.

VETERANS

As in most Congresses, those who want to get the veterans more benefits and those who think they are getting too much already are coming to grips over new bills. Important in this group is a measure proposed by Chairman Teague (D., Texas) of the House Veterans' Affairs Committee that would tighten up procedures under which veterans with non-service-connected conditions receive hospitalization. But at the same time there is pressure from other quarters for a lengthening of the "presumptive periods" for various diseases. Where the law now states that a certain disease or condition will be considered service-connected if diagnosed within one year after the veteran's discharge, these bills would make the period two or three years.

Many other bills aimed at liberalizing veter-

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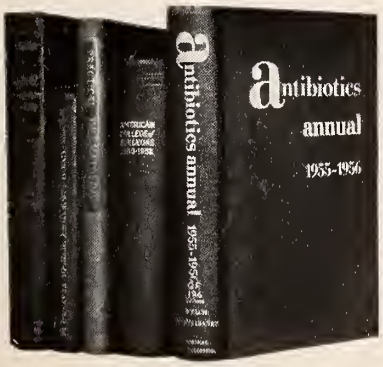


1. Romansky, M.J., et al., Antibiotics Annual 1955-1956, p. 48.
2. Waddington, W. S., Maple, F. C., and Kirby, W. M. M., A.M.A. Archives of Internal Medicine, 1954, p. 556.

ans' benefits in various ways also are waiting committee action.

SOCIAL SECURITY AND TAXES

Social security and taxes are other popular fields for the legislators. As expected, several bills call for lowering the age at which a disabled person can start receiving his social security pension, now set at 50. Many measures would change the income tax laws to allow more credit for medical expenses, and one proposes allowing the taxpayer to deduct premiums for health insurance from his income tax itself.

Of major interest to physicians and most self-employed is the Jenkins-Keogh legislation, which would allow deferment of taxes on a portion of income put into retirement plans.

CONTROL OF DRUGS

Again, a number of lawmakers want the federal government to take a more active part in control of narcotics, barbiturates and amphetamines and treatment of addicts. One suggestion is to consider any shipment of barbiturates or amphetamines as a part of interstate commerce, on the theory that intrastate control is essential to interstate control. This and other bills also call for strict record-keeping and registration (physicians excepted from these provisions).

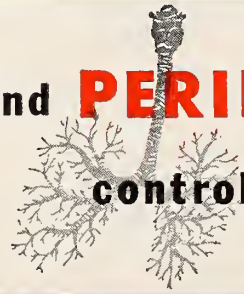
A plan introduced in the last session and offered again would give the President the right to assume control over the production, distribution and use of any drugs or biologicals "for use in the prevention and treatment of disease."

Other medical bills will of course be introduced as the session moves on; those discussed here already are assured of considerable attention.

Professor: "What do you know of Latin syntax?"

Freshman: "Did they have to pay for their fun, too?"

Both CENTRAL and PERIPHERAL control of cough



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Norways, Pioneer Psychiatric Hospital, Announces Plans to Close After June 1

BY RESOLUTION of the Board of Trustees Saturday, February 9, it was decided to close the Norways Foundation Hospital some time after June 1, 1957. Final termination date and plans will be announced in the months ahead.

The principal factor leading to the decision is the continuing low patient census. To lower the costs of operation to continue with the present inadequate census, it would be necessary to decrease the quality of care below that of Norways Hospital's traditional standard.

It is the considered opinion of the Board that it would be extremely unwise and financially impractical to continue the sponsorship of such a specialized psychiatric facility in Indianapolis. Accordingly the Indianapolis Hospital Development Association has asked the Methodist Hospital to investigate the possibility of supplying up to 100 beds in a psychiatric unit.

Norways will continue to receive patients and provide the usual range of services until the closing date. Steps will be taken to assure patients of transfer to adequate facilities, and to provide loyal employees with termination pay.

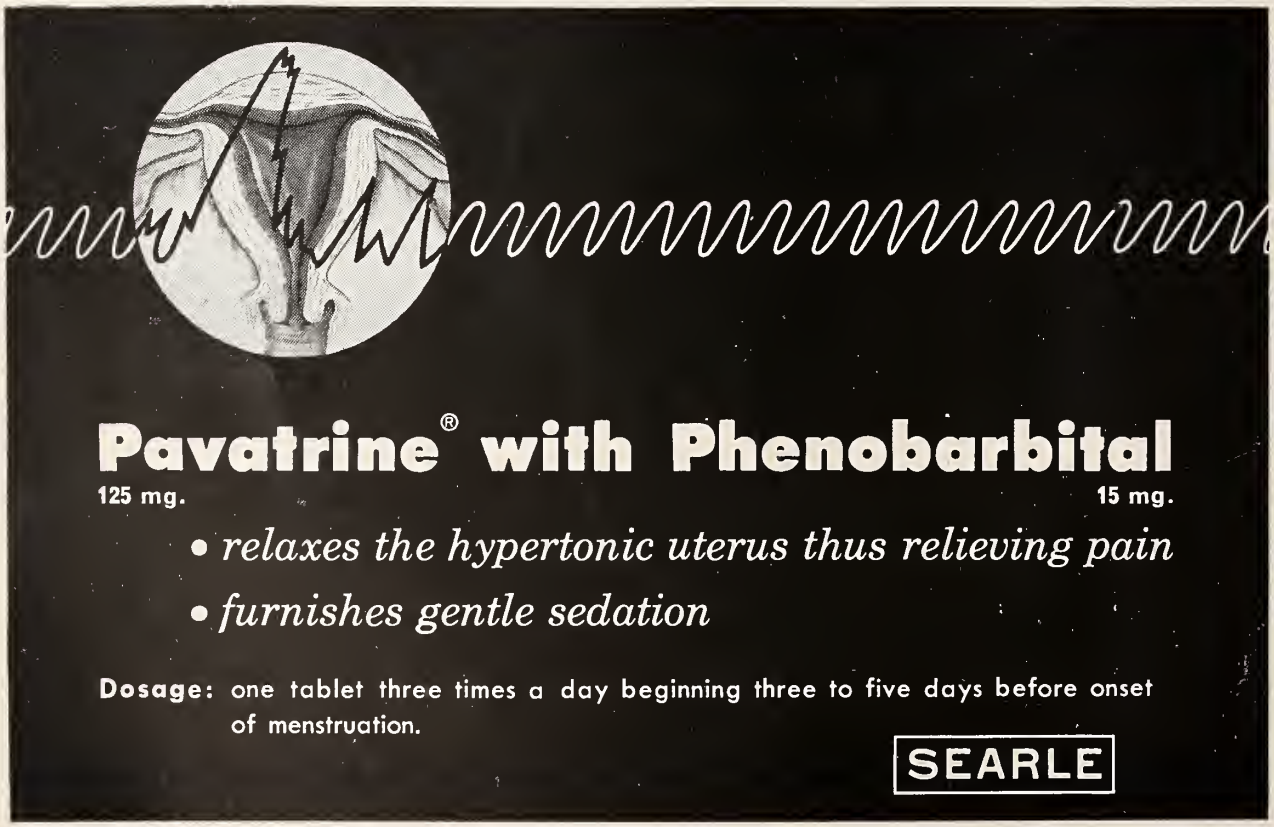
Norways Hospital has given a noble and worthwhile service throughout the years and can be very proud of its contribution to the care of the mentally ill. The Foundation plans to continue to function, and is looking forward to further service in the future.

Worried man to psychiatrist: "All day long I eat grapes."

Psychiatrist: "So what? Lots of people eat grapes."

Worried man: "Off the wall paper?"

in dysmenorrhea



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The Fourth Estate Looks at Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

DOCTORS WANT CASH

With eight years of socialized medicine experience, some 40,000 British doctors are talking of going on what amounts to a strike. Their incomes have been frozen since 1951, and they want a 24 per cent pay boost to keep them abreast of Britain's inflated living costs.

This state of affairs presents the best argument against socialized medicine we've encountered. With the individual's personal ability of such small account, and with no incentive to be superior, we can't see much future for British medicine's ability to attract men who aren't mediocre.

And it's highly alarming to think of the sick and the hurt having to put their faith in practitioners who went into medicine because it offers steady work (even if the pay is poor) and a white collar. In light of what's happened to Britain's 40,000 unhappy doctors, that appears to be about the most that can be said for the profession under socialized medicine.

We can't imagine that many people would be happy over calling in a doctor who assessed his profession that way.

The Hammond Times

CAPTIVE PROFESSION

Britain's 35,000 doctors enlisted in socialized medicine have been turned down by the government in their demand for a 24 per cent increase in pay. The government's cry is poverty and it is to be doubted that things will change much before they return three weeks from now to repeat their plea.

When the doctors were brought into the government health service about 10 years ago, they were told that the state would see to it that their pay was sufficient to maintain the prewar living scale of 1939. In the last five years the doctors have received no increase in compensation. Meanwhile, living costs have been climbing. So the doctors say that the government has gone back on its word.

In the wave of nationalization in Britain under the Labor government a decade ago, there was less opposition in the medical profession to socialization than might have been expected. Only about 500 doctors have refused to go on the state payroll. The others may have thought they were getting a good thing in built-in protection against inflation, but they now have reason to know better. The word of the government has proved no better than the word of government usually is. The doctors are hooked as members of a captive profession.

True, they have not entirely lost their spirit, for there are some mutterings about boycotting the system of socialized medicine in order to back up their pay demands. But, in another generation or so, the last spark of independence ought to be extinguished. The state by then should be operating on a system under which it chooses candidates for medical training, finances their education, and moves them into the medical burocracy. If they won't play ball, they won't be doctors.

Liberty is usually won away from the individual by promising some enticement. British patients were to get their medical care and hospitalization practically "free," along with wigs and false teeth. British physicians were to be protected against the hazards of declining money values. The promise to the doctors is repudiated. The care of the patients is something else again. We wonder how good it can possibly be when it is supplied by men who have a grievance against their state taskmaster and who feel they have been cheated.

—Chicago Tribune

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 50 — March 1957 — Number 3

Chronic Gastric Ulcer*

FREDERIC W. TAYLOR, M.D.

Indianapolis

THERE ARE CERTAIN FEATURES of chronic gastric ulcer which set it apart from peptic ulcers and add to its medical interest and importance. These might be enumerated so as to focus attention on our subject.

First of all, while the object of our discussion is as old as medicine itself, it has not been worn threadbare by recent exhaustive discussions. For that matter it has been occasionally overlooked and completely overshadowed by its associate, the duodenal ulcer.

Second, it is too often loosely considered with duodenal ulcer under the general title of peptic ulcer. While the two may have the same general origin their course and outcome are far apart. As we will see, the two demand completely different care and consideration.

Lastly, a study of the facts dictates a very different course of therapy for gastric ulcer than for ulcers just distal to the pylorus. This difference has become more definite with the passing of time and its moral has become more clear.

At the onset it might be well to define the type of ulcer under consideration. This is the usual chronic ulcer found anywhere in the stomach but with a predilection for the pre-pyloric area. Not under consideration are the acute gastric ulcers with their tendency to exsanguinating hemorrhage.[1, 2] Also, not under scrutiny are the acute perforations which may occur just on the gastric side of the pylorus. These perforations are identical in signs, symptoms and effect with those in the duodenum. It makes no difference on which side of the pyloric vein they occur—their potential is the same, the treatment of the perforation is the same. Hiatus herniae with associated gastric ulceration are distinct entities and should more properly be considered with disorders of the esophagus. Likewise, marginal ulcers are dropped from our consideration, since they are by no means primary lesions.

The chronic ulcer under discussion has margins which are thick and crater-like. Its pitted ulcer is one to three centimeters in diameter and is surrounded by a varying amount of scar. It takes weeks, months or years to reach this advanced classical form. Any tendency to perforate is retarded by adherence of adjacent tissue and

* Given as part of a discussion of the Surgical Problems of Middle Age, Indiana State Medical Association Convention, Indianapolis, Indiana, October 18, 1956.

organs. Hence perforation into the free peritoneal cavity is rare.

Massive hemorrhage from chronic gastric ulcer is infrequent. Anemia from slow blood loss is at times severe. The cause of such an anemia may be quite obscure when the offending site is not suggested by pain.

Pain is a frequent feature because irritation of overlying peritoneum is fairly constant. The type of pain is completely dependent upon the viscus or area in the peritoneal cavity which is irritated by the inflammatory process.

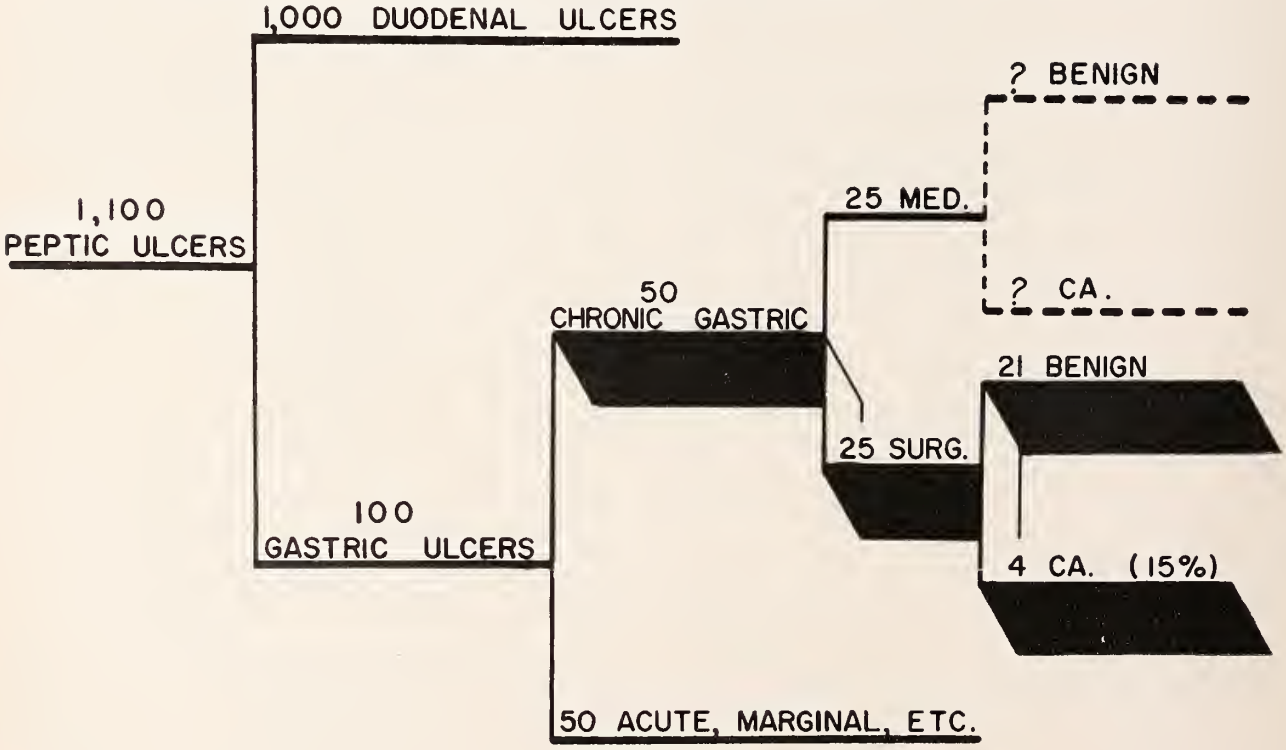
The cause of chronic gastric ulcer undoubtedly is closely related with the general peptic ulcer complex of pepsin plus high gastric acid levels. However, it differs from its duodenal neighbor in that it appears in a much milder environment. The acid level is lower and in fact may be within normal range.[3] The night acid secretion is appreciably less in amount and degree than in duodenal ulcer.[4]

The incidence of gastric ulcer is much less than that of duodenal ulcer. In this country the ratio of gastric to duodenal ulcer is one to ten or twelve.[3, 4] It is seen in man about two to three times more frequently than in woman. Thus the sex incidence is much more nearly the same in gastric than duodenal ulcer.

Although gastric ulcer is a relatively mild form of ulcer diathesis, it exacts a heavy toll with its complications. These include obstruction, perforation, hemorrhage and, of most importance, its association with gastric cancer.

It is not our purpose to enter into the controversy over the transition of benign gastric ulcer into gastric cancer. That the two are frequently seen together cannot be denied. However, it is generally believed that the benign ulcer does not become malignant. It seems more likely that gastric carcinoma at times undergoes peptic digestion and mimics a benign lesion—in fact may nearly destroy the carcinoma. The possibility must be accepted that occasionally a benign ulcer may become malignant.

FIGURE 1: Graphic representation of peptic ulcer distribution at the Indianapolis General Hospital over a three-year period. (Study covered years 1945-1950). Question marks indicate the number of malignancies in the medically treated gastric ulcer group cannot be accurately determined.
Also indicated below—that during this same period 50 gastric cancer patients were seen and treated at the hospital. All were dead five years later.



50 GASTRIC CA. → 5 YRS. → ALL DEAD

In order to bring the problem closer home it seemed of interest to review a group of our local cases. For this purpose we chose to analyze all the chronic gastric ulcer cases which were treated as in-patients in the Indianapolis General Hospital in the ten year period 1945-1955. During this time 162 such patients were admitted to the hospital and were proved by x-ray or operation to have chronic gastric ulcer. Other types of gastric ulcer were not included in the study.

The cases ran very close to form and with few exceptions paralleled other similar reviews. The ratio was one female patient to three males. The ages of the patients varied from 27 to 84 years with the average being 57.5 years.

Symptoms were present for periods of a few days to 25 years. There seemed to be no distinguishing clinical diagnostic features of gastric over duodenal ulcer. After varying periods of medical management 53 per cent were operated upon. The operation of choice was subtotal gastric resection although two sleeve resections and one gastroenterostomy were done.

There were 11 deaths in the operative cases. Four of these deaths occurred in desperation emergency operations in which medical management had failed. We contend that these are medical deaths, since the surgical service did not treat these cases at the onset but only as a last resort.

Medical treatment was carried out in 47 per cent of the cases studied. There were four hospital deaths in this group. In general the follow-up results of surgical treatment were better than those enjoyed by the group treated by medical measures alone and the patients were able to return to a more nearly normal life.

Accurate follow-up studies were impossible in the itinerant patients seen in our city hospital. This was disappointing, for it nullified an accurate appraisal of our therapy. It also prevented us from determining the exact number of gastric carcinomas which were associated with gastric ulcers. This particular question has been evaluated by others with rather uniform results.[5, 6] Apparently about 15 per cent of lesions treated as chronic gastric ulcers and eventually operated upon, prove to be cancers by pathological examination.

This latter point is of great significance and it is the reason for considering chronic gastric ulcers as quite separate entities from duodenal ulcers. If 15 per cent of gastric ulcers being treated medically are actually cancer—then possibly all should have primary resection without any thought of medical management.

An over-all picture of our gastric ulcer problem is shown graphically in figure 1. Here it will be seen that only a small part of all "ulcer" patients fall into the chronic gastric ulcer group. It is also noted that only half of these were operated upon and the remainder continued on medical management. The exact outcome of the latter cannot be known. Unsuspected cancer might might be expected in 15 per cent of those going to operation. The tragic courses of two such cases are sketched in figures 2 and 3. The first diagrams a virulent rapid cancer that nothing could stop and the latter indicates an overlooked cancer treated too long with the best of medical management.

If we are to save patients with gastric carcinoma it must be in these unsuspected cases. Pa-

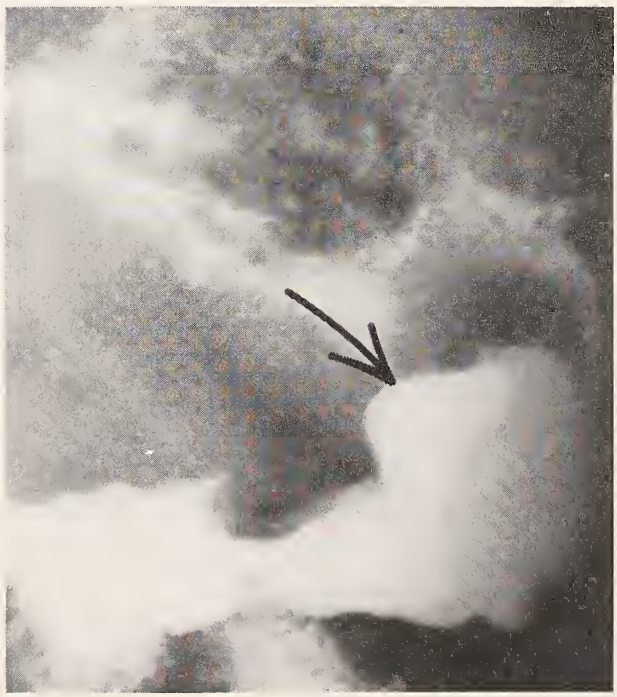


FIGURE 2: Brief detail of fulminating gastric cancer with inevitable outcome in a 29 year old man.

Oct., 1955—Epigastric and back pain.
Feb., 1956—Pain severe, saw local M.D.
March, 1956—X-rays: Lesser curvature ulcer.
April, 1956—Hospital. X-rays same (above).
May, 1956—Improvement with medical treatment. X-rays same.
June, 1956—Pain continued. Surgery. Metastasis to liver, peritoneum, intestine.
July, 1956—Dead. Nine months after onset. Five weeks after hospital admission.

FIGURE 3: Résumé of 75 year old man treated "conservatively".

Dec. 1950—Gnawing ulcer pains. Medical treatment.

Dec. 1951—Vomiting blood. Melena. Hospital admission. X-ray questionable gastric ulcer (above). No free Hcl. Medical management.

Jan. 1952—X-ray negative on two examinations. Gastric ulcer by gastroscopy.

Mar. 1952—X-ray negative. Ulcer healing by gastroscopy.

May, 1952—X-ray normal. Ulcer healed by gastroscopy.

Oct. 1952—Pain. Normal X-ray on two occasions. No free Hcl.

Nov. 1952—Gastroscopy demonstrated malignant lesser curvature ulcer. Surgery—Cancer with omental implants 11 months after hospital admission, 23 months after symptom onset.

Apr. 1953—Asymptomatic. Weight loss, downhill.

Aug. 1954—Died.

tients with lesions which are definitely diagnosed carcinoma before operation will not be saved. They are too far advanced. Last year Dr. Dempsey Strange and the writer reviewed all the gastric cancer cases seen between 1945 and 1950 at the Indianapolis General Hospital, the Veterans Hospital and the University Hospitals. There were 181 such cases. Of these we could find no one alive five years later. True, we have some five year survivors in other years but none for the particular five-year period chosen for study. From this experience we are convinced more than ever that gastric carcinoma diagnosed before operation will not be cured. The cures must come from gastric resections for lesions which clinically are still ulcers and have none of the roentgenological earmarks of cancer.

It is interesting to note that while the 50 chronic gastric ulcer cases noted in figure 1 were being treated at the Indianapolis General Hospital, approximately the same number of gastric cancer patients also were being seen and treated. As just stated, none of these survived five years.

SUMMARY

1) Chronic gastric ulcer constitutes only a small part of the over-all peptic ulcer problem.
2) Chronic gastric ulcers are associated with an appreciable number of unsuspected gastric carcinomas. Therefore the treatment of gastric ulcers cannot parallel that of other peptic ulcers.
3) If we are to make any inroads upon gastric cancer it will not be in the group in which the diagnosis is obvious. The improvement will come from removing the lesion which clinically is still an ulcer but which on pathological section also includes carcinoma.
4) We cannot advocate immediate gastric resection on all cases of gastric ulcer. On the other hand too many gastric ulcer patients are "treated to death". Surely gastric resection is mandatory in a patient past middle age, with achlorhydria and a gastric deformity.
5) The operative treatment of benign gastric ulcer is a very satisfactory procedure.

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Male Urinary Retention and Cardiac Decompensation: A Relationship

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THE OBJECTIVE of this paper is to show relation of two clinical entities. Apparent low grade bladder neck obstruction may cause acute urinary retention in the presence of cardiac decompensation. Conversely, a chronic bladder neck obstruction may lead to acute cardiac decompensation. At first thought, the association is so apparent that one would believe that attention should have been called to it before. However, very little in this regard is said in current texts of cardiology or urology. The current literature also is almost devoid of mention of the problem. In the modern day management of the case of congestive heart failure, we use sodium restriction diet, carefully attend the electrolyte balance, carefully use digitalis and its derivatives, rid the patient of excess body water by diuretic means, only to forget, perhaps, the absolute necessity of the male patient to eliminate this water through the urethra.

An interest in the two sides of this problem was excited by seeing sequentially two patients, both with cardiac decompensation and both with urinary retention. In one cardiac decompensation precipitated complete urinary obstruction. In the second, chronic bladder neck obstruction precipitated cardiac decompensation.

The first case was a 73 year old retired farmer. His complaints were shortness of breath, inability to lie flat, cough with foamy, frothy and pink-tinged sputum and symptoms interpreted as paroxysmal nocturnal dyspnea. The onset of his difficult breathing had been about four to five years earlier, but had been marked for one year. He had had paroxysmal nocturnal dyspnea for at least six weeks accompanied by all of his other complaints. On May 21, 1954, his urinary flow had suddenly stopped. For two months he was catheterized daily. At this time, I first saw the patient. His past personal history included typhoid fever, measles, smallpox, mumps and an episode of hepatitis. His family history was not relevant and system review revealed no additional information. He was a small, emaciated man with a marked kyphosis. The angulation at the dorsolumbar juncture was almost a right angle. His temperature was 98.6°, pulse 100, blood pressure 170/90 in the right arm, 160/90 in the left arm and weight 136½ pounds. The examination of the head and neck was not remarkable. There was an increase in the anterior posterior diameter of the chest. The cardiac apex was 11 centimeters to the left of the midsternal line in the anterior axillary line. The heart rate was rapid with many extrasystoles present. A musical systolic murmur was heard at the apex and along the left sternal border. Its intensity was such that it could be heard over the entire precordium. There was a systolic and diastolic murmur at the aortic area. The left lung base was dull to percussion and there were moist rales in both bases. The abdomen was scaphoid, nontender and no masses were present. The external genitalia were those of a normal male. Rectal examination did not show the prostate to be enlarged and there were no masses felt on digital examination. There was a three plus pitting edema of the feet and legs extending almost to the knees. Varicosities were very marked in this same area. Neurological examination was normal. Following physical examination the patient was catheterized following his unsuccessful attempt to void. The patient was catheterized with a No. 14 straight catheter after unsuccessful attempts to pass larger sizes. Five hundred cubic centimeters of urine was obtained. The diagnosis was made of arteriosclerotic heart disease; rheumatic heart disease, inactive, decompensated

class 3; and bladder neck obstruction with urinary retention.

The patient regained cardiac compensation and on June 8, 1954, was examined by cystoscopy. The bladder revealed evidence of long standing urinary obstruction. The prostate showed a bilobed hyperplastic gland with a fibrous contracture of the bladder neck. The excretary urogram was normal. A complete transurethral prostatic resection was done. The patient's post-operative period was uneventful. The catheter was removed on the third postoperative day and the patient has been easily managed since. He has had no difficulties in the continued passage of his urine. It was felt in this instance that a patient who had had a long standing decompensated cardiovascular problem suffered accentuation of urinary retention due to edema resulting from the decompensated state. The primary cause of the urinary retention was the previously existing prostatic hyperplasia.

The second case was that of a 67 year old paint contractor. He was seen initially on October 6, 1951, complaining of difficulty in passing his urine. This problem had been present for approximately one year. On examination, a residual urine of 14 ounces was found and a large hyperplastic gland was felt per rectum. At this time the serum alkaline phosphatase was 1.8 Bodansky units. It was felt that the patient had a benign hyperplastic prostate. In addition, it was noted that he had a left hydrocele. A recheck on October 23, 1951 demonstrated that the patient could empty his bladder. He was not seen again until November 7, 1953 at which time in the process of system review he stated that he had had nocturia two times a night with burning on passage. He had no other difficulties and felt well.

His blood pressure was 210/100. His weight was 154 pounds. He had a marked scarification of the right eye, otherwise the examination of the head and neck was not remarkable. The lungs were clear. The heart was normal. The abdomen was protuberant. There were no scars and no free fluid was found. The liver, kidneys and spleen were not enlarged. There was a left hydrocele. Rectal examination showed a few small hemorrhoids and the prostate was enlarged. The extremities were normal. Blood and urine were normal.

At this time he was given no medication, but informed of his prostatic hypertrophy and the probable consequences. He was later seen May 6, 1954 complaining of a bad taste in the mouth, discomfort low in the abdomen and that for a period of two days he had not been able to urinate well. At this time his blood pressure was 200/120, he was tender in the right upper quadrant, the hydrocele had enlarged, the prostate was extremely enlarged. He was seen as an emergency a few days later with extreme shortness of breath and a sense of constriction in the chest. His temperature was 98.4, pulse 80, blood pressure 180/120 and there were rales in the left base. At this time he was recovering from an episode of rather severe nocturnal dyspnea. He was placed on a 1,000 mgm. sodium diet, 1,500 calories. A #18 Foley catheter was anchored. Electrocardiographic changes of left ventricular hypertrophy were present. When compensated he was permitted to be at home with catheter drainage until he returned to the hospital for urological surgery. He had a non-functioning left kidney without evidence of infection, but with mechanical obstruction in the middle third of the left ureter. Marked benign prostatic hypertrophy was found with a bladder retention of 900 cc. of urine. Subsequent to transurethral prostatic resection on June 21, 1954 the patient has had no recurrence of precordial pain or nocturnal dyspnea.

MATERIAL

In an effort to approach this problem with the utmost objectivity, no effort was made to screen the cases collected. The most recent admissions presenting with cardiac decompensation as the primary complaint (100) were analyzed for evidence of bladder neck obstruction. Second, the most recent admissions (100) presenting with bladder neck obstruction as the primary complaint were analyzed for evidence of cardiac decompensation. This data is presented in tables 1 and 2. These cases were drawn from the files of the Indiana University Hospitals and from the Medicine and Urological services.

DISCUSSION

A few relatively brief observations are made in texts and in the current literature. One of the earlier observations was that of Willius[1], who stated "The patient who is decompensated often develops an acute retention due to edema of the bladder neck".

Friedberg[2], in his text, writes that "urinary

TABLE 1

100 male patients admitted for heart disease with decompensation

Age Decade	Number admitted in each age decade	Number found to have urinary retention due to prostatism	Number with no rectal examination recorded
10-19	2	0	0
20-29	7	0	1
30-39	0	0	0
40-49	19	3	2
50-59	14	2	0
60-69	28	10	9
70-79	21	14	4
80-89	9	8	0
90-	0	0	0
Total	100	37	16

TABLE 2

100 male patients admitted for prostatism and urinary retention

Age Decade	Number admitted in each age decade	Number found to have heart disease	Number found to have cardiac decompensation	Number with no rectal examination recorded
10-19	0	0	0	0
20-29	0	0	0	0
30-39	0	0	0	0
40-49	2	1	1	0
50-59	8	2	1	0
60-69	19	9	6	0
70-79	43	16	12	0
80-89	24	13	11	0
90-	4	2	1	0
Total	100	43	32	0

obstruction, due to prostatic hypertrophy, and other urologic diseases are among the commonest conditions in cardiac patients for which operation is performed. The surgical and cardiac risks are further complicated by the advanced age of the patients which average between 65 and 70 years. Arteriosclerotic and coronary disease are common. Postoperative coronary occlusion is not rare. Cardiac patients will deteriorate if they chronically suffer from prostatic disease with or without urinary retention. Frequency of urination with its attendant interference with rest, straining to void and the adverse effects of the prostatic disease on the kidney function, impede any recovery from a decompensated heart. Cases of heart failure definitely improve after adequate drainage of an obstructed bladder".

In 1942, 1943 and 1949 various articles have appeared by Schneidersen and Bergman[7] and by Plotz[5, 6] which point out without any reservation that male patients given opiates and mercurial diuretics at the same time are not unlikely to develop acute urinary retention. Schneidersen and Bergman[7] pointed out that a large portion of the patients treated for congestive heart failure are middle aged or elderly men and not a few of this age distribution have had bladder symptoms, the result of varying degrees of obstruction of the bladder outlet occasioned by prostatic enlargement. Many of these people with definite urinary tract symptoms have not sought medical aid for this problem. Reference is made to an article by Scherning as early as 1927 in which he stated that men in whom acute urinary retention developed after mercurial injections are those with a hypertrophy of the prostate in whom additional acute swelling of that area accounts for a complete obstruction of the bladder. The rapidity with which acute retention developed in a number of cases shortly after the increased renal excretion of urine led them to theorize that the sudden distention of the bladder was a very important factor. None of these, excepting Willius, have suggested the probability that the actual acute retention might be due to sudden acute edema of the bladder neck, prostate and surrounding tissues as a result of cardiac decompensation.

It is interesting to note that in the group of those patients admitted with bladder neck obstruction as the presenting complaint, that the predominating age group is from 60 to 69 years and the accompanying incidence of heart disease is higher in this spread than in all other age groups. Congestive failure occurred in these patients most frequently also; and approximately one in four was found to be so involved.

In examining the records of patients admitted with cardiac decompensation, it was distressing to find that no examination of the prostate was recorded in 16 of 100 cases and little or no attempt was made to evaluate the male patient's ability to void. The incidence of heart disease rises sharply at the fortieth year to a peak in the 60-69 year group. The greater number of patients with bladder neck obstruction is in the 70-79 year old group and there is an average greater number from 60-90 years. It will be

noted that the year incidence of heart disease and bladder neck obstruction in the male coincide very well.

In a review such as this, no conclusions may be allowed. However, a few observations may be made:

In a review such as this, no conclusions may be allowed. However, a few observations may be made:

1. Bladder neck obstruction with or without urinary retention and heart disease increase in incidence in a parallel manner with age in the male.

2. Treatment of the patient with bladder neck obstruction demands a thorough investigation of his cardiovascular status.

3. Cardiac decompensation with edema of the bladder neck, prostate and associated tissues may precipitate, in an already partially obstructed male, an episode of acute urinary obstruction.

4. Treatment of the male cardiac patient demands a thorough investigation of the patient's ability to void.

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DOCTOR CALLS FOR WIDER USE OF CHEST X-RAYS

A Wisconsin radiologist has listed several reasons why a chest x-ray should be part of the routine procedure when a patient enters a hospital.

Dr. Abraham Melamed of Evangelical Deaconess Hospital, Milwaukee, and St. Joseph's Hospital, West Bend, Wis., said in the Journal of the American Medical Association that routine chest x-rays are performed in only 30.1 per cent of all the hospitals in the U. S.

Routine x-rays should be done in all hospitals, he said, because:

They uncover many previously unsuspected cases of chest abnormality or disease, especially tuberculosis and heart disease. Prompt treatment decreases the length of hospitalization, lengthens life, and stops the spread of communicable diseases.

They prevent some errors in diagnosis, since the films may be used as checks against other findings.

They provide valuable information to doctors preparing patients for surgery by showing the condition of the patient's lungs and heart. In this way the x-ray findings often have a direct bearing on the choice of an anesthetic.

They provide a permanent record of a patient's chest condition during past hospitalizations. This helps make diagnosis of current conditions more reliable and accurate.

Since more than 20 million patients are annually admitted to hospitals in the U. S., x-ray films could provide valuable data for the study of various diseases, their effects, and their incidence.

X-ray films can be important records in compensation and accident cases. They show the condition of the patient immediately after the accident and can even reveal unsuspected injury.

They play an important role in the teaching program of the hospital, by providing the staff with an opportunity to learn the appearance of average or normal chest x-rays, which can then be compared with films of diseased chests.

New Psychotherapeutic Drugs

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A CONTINUAL FLOW OF INQUIRIES about drugs for tranquilization not only failed to produce equanimity in our Department of Pharmacology, but is responsible for this article. The recent origin of these drugs, their multiplicity of effects and seeming lack of fit with many classical concepts of drug action all contrive to make conclusive discussion impossible. The following should be considered as an interim report on developments in this rapidly expanding and most interesting division of pharmacotherapeutics.

These agents have been called mood drugs, don't give a damn pills, happy pills and other such vague sensual terms by the lay press. Initial investigative reports referred to them as tranquilizing agents. Dr. Fabing has recently proposed that these be labeled ataraxics** or ataractic agents.[1] The widespread usage of these latter terms indicates the acceptance of Dr. Fabing's proposal. Terms such as psychotropic agents and phrenotropic agents have also been used in the many reports on the psychopharmacology of these drugs. The ataraxics can be differentiated from other central depressants in that they possess a special type of calming action with little or no dulled perception, impaired natural reflexes or somnolence. There may be a strong resemblance of ataraxia to the daytime sedation effected by subhypnotic doses of dormifacients. The line of distinction is not easily definable at present.

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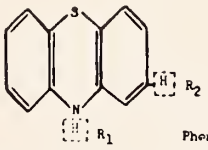
** From ataraxia (Greek) meaning calmness, untroubled by mental or emotional excitement.

CHEMICAL CLASSIFICATION

Let us examine the chemical formulas of these compounds for the special purpose of seeing if they can fit any chemicopharmacological classification.

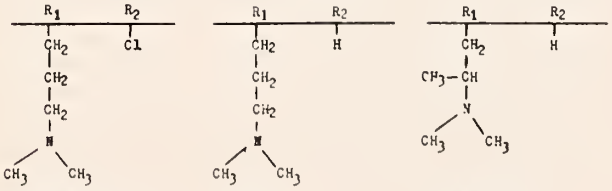
PHENOTHIAZINE DERIVATIVES

The derivatives of phenothiazine form a special chemical group, several of which have been reported to have this effect of producing sedation without hypnosis. Phenothiazine has the following formula:



Phenothiazine

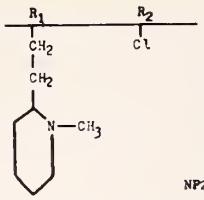
This compound has anthelmintic action which is not sufficiently outstanding to warrant its use in view of its toxic action on red blood cells. Its therapeutic usage today is reserved to veterinary medicine. It is mentioned here only to demonstrate the similarity in chemical structure of the agents which are to be mentioned below. Substitution or alteration of the above compound in the following manner results in drugs, all of which have definite ataractic activity; chlorpromazine (Thorazine, Largactil), promazine (Sparine), promethazine (Phenergan).



Chlorpromazine (Thorazine, Largactil) Promazine (Sparine) Promethazine (Phenergan)

Another derivative is NP 207 (Sandoz) which

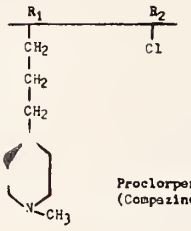
has been reported in the current literature, but is still under clinical investigation and evaluation.



NP207

Early studies of this compound indicate that the therapeutic effects are comparable to those of chlorpromazine. Results of animal studies show that its pharmacology does resemble that of chlorpromazine, but the oral toxicity to both rats and mice is about one-half that of chlorpromazine. A late occurring incidence of toxic retinitis in a high percentage of clinical subjects has delayed the introduction of this compound into modern therapeutics.

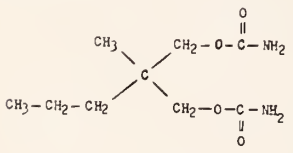
One might assume from the toxicity of NP 207 that substitution of an aromatic ring structure on the end groupings would increase the toxicity; but the following compound (Proclorperazine) also has a cyclic addition (methyl piperazine) and the resultant product is less toxic than chlorpromazine from which it has been evolved.



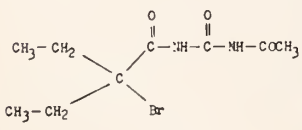
Proclorperazine (Compazine)

UREIDES

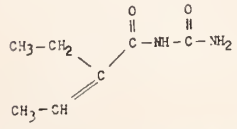
Another chemical class of ataractics are represented by the following drugs which are derivatives of urea. As a class, the ureides have been known for many years and the diureides (barbiturates) have been the most prominent of this group because of their greater hypnotic properties.



Meprobamate (Miltown, Equanil)



Acetylcarbromal (Sedanyl)

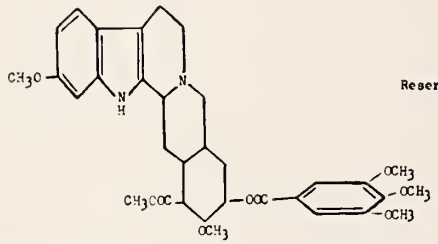


Ethylcrotonyl Urea (Nostyn)

From the above structural formulas it is evident that these two compounds are chemically related. The above formulas are noticeably unlike the phenothiazine derivatives of the preceding class. We will mention later how these two groups also differ as regards physiological responses which they induce.

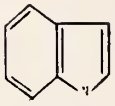
DRUGS WITH INDOLE NUCLEUS

Reserpine is an alkaloid, which is derived from the crude drug, Rauwolfia serpentina. It represents still another chemical group, for its formula below indicates that it is unlike the previous ataractic drugs.



Reserpine

A glance at the general structure of reserpine will reveal that the indole nucleus is contained therein.

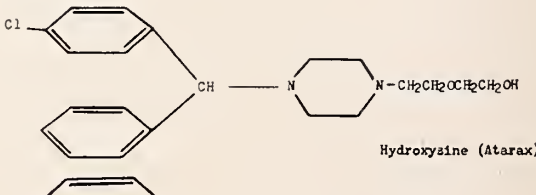


Indole Nucleus

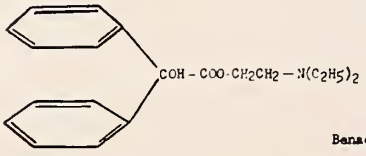
Serotonin contains the indole nucleus and has been implicated in the metabolism of the central nervous system and reserpine may act as an antimetabolite because of this indole portion of the molecule.

DIPHENYLMETHANE DERIVATIVES

The two compounds illustrated below show some structural relationship, although their pharmacological activity is certainly not superimposable.



Hydroxyzine (Atarax)

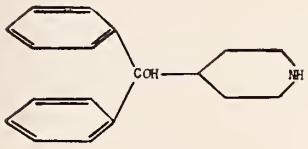


Benactyzine (Suavitil)

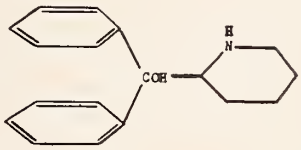
Benactyzine is very closely related chemically to adiphenine (Trasentine), differing only in that it contains the hydroxyl group as illustrated

above. Adiphenine is a peripherally acting antispasmodic, especially on the gastrointestinal and genitourinary tracts.

The relationship of these two compounds is obvious. They also show some similarity in general structure with the two following drugs:



Azacyclonol (Frenquel)

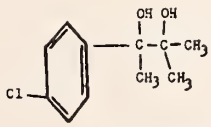


Pipradol (Meratran)

These two latter compounds are analogues, differing only in the position of the NH radical, but they are unlike pharmacologically. Pipradol has a stimulant action on higher centers. Azacyclonol blocks the hallucinatory and delusional symptoms produced by lysergic acid diethylamide and so has been classified as an anti-hallucinatory drug. Cohen and Parlous[2] were not able to elicit the anti-hallucinatory property in functional psychoses but do classify it as an ataractic drug.

PHENYLALKANES

Another of these psychotropic agents is phenaglycodol (Ultran) whose formula is indicated below. This compound also contains the chlorine atom which was evident in so many of the previous compounds. Otherwise, its chemical configuration is one that is not common to the others. It has a striking resemblance to many sympathomimetic amines, but is the only compound in the ataraxics herein listed that is not an amine.



Phenaglycodol (Ultran)

This examination of the chemical structure of these compounds has been made for two purposes; first, to correlate certain likenesses in chemical structure with similarities in pharmacodynamics, secondly, to point out obvious dissimilarities in chemical structure which may help us to understand certain differences in the pharmacology of these drugs. It is obvious that the ataraxics do not all have a basic nuclear structure which has been altered in various ways, as is true with the barbiturates and many other groupings of drugs.

LOCUS OPERANDI

The site of action of most ataraxics is said to be at *sub*cortical levels of the brain. The term *sub*cortical, of course, is one of exclusion and is widely used because of the relatively inadequate physio-geographical description of the higher centers, other than the cerebral cortex.

The sedative action of the barbiturates is due to cortical and subcortical depression. The tranquilizing agents act predominantly on subcortical levels of the brain or, to be more specific, at the hypothalamic level or on the reticular activating system. However, certain of these drugs (as the phenothiazines) do exert some cortical effect which may be overlooked.

Chlorpromazine has been the subject of more investigative reports than any of the other drugs mentioned in this discourse. There is universal agreement that the myriad of physiological responses that it produces are due mainly to its action on the central nervous system. Still, these many reports also indicate that chlorpromazine does not have a single site of action. There is evidence also for some peripheral effects, as well as influences on the cortical area, the thalamus, the hypothalamus, the basal ganglia, the medullary centers and the brain stem reticular formation. This reticular formation has been ably described by Magoun[3] as an area in the cephalic brain stem and adjacent areas that lies parallel with the long afferent and efferent neural systems, and receives connections from both of them. Efferently it contributes to optimum motor performance and afferently induces a state called wakefulness or alertness upon which most higher functions of the nervous system depend. Earlier reports on chlorpromazine emphasized the action on the hypothalamus, but later studies have accentuated its action on this central core of gray matter in the brain stem which functions in the alerting mechanism. Because of the multiplicity of sites of action of chlorpromazine, Ayd has offered the theory that chlorpromazine is nonspecific in action but alters the synaptic transmission in all parts of the central nervous system[4].

Although the many clinical findings also indicate that chlorpromazine has numerous sites of action, the predominant depressant activity on the reticular structure appears to be the most likely explanation for the main ataractic properties of this compound. Electroencephalographic records, in the case of chlorpromazine, resemble

those of sleep, but those of the barbiturates and other hypnotics, which are thought to act primarily on the cortex as well as on the midbrain, do not.

There are many reasons for believing that reserpine primarily acts centrally. Many peripheral effects, such as miosis, are prevented or reversed by excision of peripheral ganglia. In contrast, peripheral loci of action are recognized for chlorpromazine. Reserpine, in all doses, will evoke the alerting reaction and this is why it is a sedative without being a hypnotic. It is the hypothalamus especially which is depressed and the suspension of the activity of the sympathetic center results in sedation but the stimulation of the reticular activating system then acts as a buffer against sleep. Chlorpromazine, in contrast, depresses the alerting mechanism of the reticular zone, and since this is its primary site of central action, the mean resultant effect is that of sedation without sleep. The reports of the anti-hallucinatory or de-confusing activity of azacyclonol (Frenquel) have been supported and challenged. The evaluation of the locus of activity is no less complete.

Chlorpromazine, promazine, hydroxyzine and others of this group resemble strongly in chemical structure the antihistaminic agents. Since drowsiness is an untoward effect seen frequently in antihistaminic therapy, this was anticipated with the first of the ataractics. Yet, I would like to emphasize again that the quieting effect which is produced from therapeutic dosages is quite different than is seen with bromides, paraldehyde, the barbiturates and even the antihistaminics. Reports of tests on rats exemplify this difference; reflexes that have been conditioned in these animals continue to be present after barbiturates until evident drowsiness is obvious. During treatment with chlorpromazine the animals cease to respond reflexly to certain painful stimuli to which they have been conditioned with dosages that are much less than that required to produce a state of sleep or near-sleep.

Meprobamate (Miltown, Equanil) acts on the central nervous system being an interneuronal blocking agent, relaxing skeletal muscle without affecting peripheral nerves or the myoneural junction. It was introduced as a muscle-relaxing drug as a result of studies that compared it with Mephenesin. These studies have shown it produces a flaccid paralysis of skeletal muscle in animals, but has a duration of action approximately 8 to 10 times that of Mephenesin. On the other hand, unlike Mephenesin, it displayed a calming effect on animals without impairing alertness. Mephenesin is known to have no effect on normal electroencephalographic patterns in doses that abolish involuntary movements or tremors. Meprobamate abolishes the asynchronization of the electroencephalographic record which is responsible for a normal waking record and this is more evident in the subcortical areas, particularly in the thalamus, than is seen on cortical activity. With very large doses a record characteristic of physiological sleep is obtained. Like meprobamate, acetylcarbromal (Sedamyl) acts on the higher centers of the brain to produce a tranquilizing and calming action without the drowsiness or hypnosis of the barbiturates. Neither of these compounds affect the autonomic functions directly nor do they have any true analgesic effect. Acetylcarbromal does not share the depressant effect on multineuronal reflexes.

Benactyzine (Suavitil) is quite different in chemical structure from chlorpromazine, reserpine and meprobamate. It is also unlike these drugs in pharmacological properties.[5] Benactyzine is anticholinergic in peripheral action and, like atropine, causes a slowing and increase in amplitude of waves of cortical and subcortical areas as well. Both of these responses are similar to that seen in the barbiturate-induced depressive patterns. In mice and monkeys, benactyzine, in large doses, causes profound central excitation leading to convulsions such as is seen with overdosages of most of the antihistamines. The site of these profound central effects of this agent cannot be located at present. However, there appears to be a cortical locus which is at least more predominant than the previously mentioned ataraxics. Benactyzine does not produce the characteristic taming effect in animals when compared to the three ataraxics mentioned above, and it lowers the lethal dosage of central convulsants. Despite these adverse effects it has been effective in the symptomatic therapy of anxiety and other signs of psychoneurotic disorders.

MODUS OPERANDI

The localization of the precise site of activity of any pharmacological agent is a primary advancement in the search for the explanation of the physiological responses. Of course, this does

not pronounce any finality to the search for an understanding of the action of any drug. We must seek the reasons why, and the manner in which the drug operates at this site. The previous summary of locus of action naturally leads us to the present topic of manner of activity. There is a need for the explanation of alteration of exact biochemical processes by drugs to enable us to explain many diverse pharmacological findings as well as to possibly predict untoward effects that may develop. Researchers have begun to turn to biochemical methods for the determination of the cellular manner of activity of drugs as an explanation for the response of patients under conditions of disease and health; treatment, prophylaxis and cure of such diseases.

Cellular studies of the action of chlorpromazine and other ataraxics are in the state of commencement and reports to date are fragmentary. These studies, however, illustrate that these drugs *do* alter certain cellular functions. It is hoped that further studies will indicate that measurable changes in cellular physiology are reflected by alterations of the personality as well as the physiology of the patient, if we can separate these two.

Adenosinetriphosphate (ATP) and adenosinediphosphate (ADP) serve as carriers for high energy phosphate and function as sources of cellular energy. These compounds are important in many specific sequences of catabolic reactions of the body.

In vitro studies of the rat-brain oxidative systems indicate that reserpine and chlorpromazine both cause a decrease in the oxidative phosphorylation of brain tissue.[6] At the present, we cannot specifically indicate the clinical significance of such findings. However, it is obvious that there is some selective change in the metabolic processes of the tissue of the central nervous system, when such tissue is under the influence of these agents. The researchers reporting this decrease in oxidative phosphorylation naturally thought of the hexokinase reaction, i.e. the trapping system, whereby glucose is phosphorylated as the initial process in the metabolism of this sugar. However, there is no depression of this reaction so the manner of the blockade of the energy-releasing process is elsewhere, and the other chemical reactions in which ATP or ADP are actively involved will no doubt be the subject of many future reports.

Certain vegetable alkaloids are capable of producing an hallucinatory state in man viz. mescaline, yohimbine and harmine. The semi-synthetic compound, lysergic acid diethylamide (LSD-25) effects a like psychotic state. These four compounds have an indole nucleus as a part of their cyclic structure. The psychiatrists have been interested in the indole nucleus for many years. Certain psychotic patients will excrete abnormally large amounts of derivatives of this chemical in their urine. Adrenochrome ("pink adrenalin") has been implicated as a chemical factor in certain abnormal behaviourisms. It also contains the indole nucleus and can cause hallucinations. Other compounds that have this nucleus in their ring structure and are hallucinogens are tryptamine and bufotenine. Fabing has suggested that these two compounds (tryptamine and bufotenine) may result from errors in the metabolism of serotonin and tryptophan, respectively.[7]

Serotonin (5-hydroxytryptamine, 5-HT) contains the indole nucleus but is a natural component of brain and other tissue. It has been labeled a neurohormone. Its exact neurophysiological function has not been determined, but it is suggested that many vital mental processes are mediated via the action of this neurochlormone. A deficiency of this metabolite has been implicated as an etiological factor in certain mental dysfunctions. Serotonin injected peripherally into animals does not result in an appreciable increase in the concentration of this compound in brain tissue. Evidently, some chemical precursor of serotonin must be present in order to traverse the blood-brain barrier. Serotonin is also present in smooth muscle of the body. It may be bio-assayed by its action on contractility of guinea-pig uterus.

Serotonin is, then, a metabolite of the body and many hallucinatory drugs have been called anti-metabolites, since they have a structure similar to this essential component of the body and it has been suggested that they evoke their physiological response by a deficiency of serotonin. Brodie *et al.*[8] have analyzed the brain tissue of experimental animals after the administration of ataraxics and other centrally acting drugs and have found that the serotonin level was decreased after the administration of reserpine. Yet no change in 5-HT levels was observed after the administration of Thorazine or Frenquel. This decrease in serotonin levels they interpret as a serotonin releasing activity and classify reser-

pine as an antimetabolite as an explanation for the neurophysiological actions of Rauwolfia alkaloids. These investigators also reported the failure of a number of hallucinogens (LSD-25, yohimbine, mescaline) to significantly alter the serotonin content of brain tissue. As further demonstration of the release of serotonin from the body during reserpine therapy, there is an increased excretion of 5-hydroxy indoleacetic acid in the urine. This latter component is a major metabolite in the final degradation and excretion of 5 hydroxytryptamine.[9]

From the inchoateness of these disconnected reports we can grasp a few concrete conclusions. A decrease in metabolism of brain tissue is produced as a result of the influence of chlorpromazine. The serotonin level of brain tissue is not altered by chlorpromazine, but it is decreased when under the influence of reserpine. The indole nucleus represented in the chemical structure of reserpine begins to be more conspicuous. It is likely that future chemical agents used in the study of neuro-biochemical disease and health processes will purposely contain this nucleus. Those so far have inadvertently contained therein this structure and after long-termed usage of such agents the indole nucleus began to be implicated.

PHYSIOLOGICAL RESPONSES

CENTRAL EFFECTS:

On the previous pages is indirectly described the selective type of central depression which occurs after the administration of ataraxics. This depression is clinically and pharmacodynamically unlike that observed during therapy with the hypnotics. However, a depressant state of somnolence is possible in therapy with most ataraxics. This may be an unusual idiosyncratic response of the host or a fairly common side-effect of these psychotropins. Certainly, drowsiness is not uncommon with any of these drugs, although it usually is transitory and outlasted by the ataraxy. Increase in the potential of concomitantly administered barbiturates has been closely examined by numerous investigators. The phenothiazine derivatives, as a group, do consistently potentiate barbiturate-hypnosis. Meprobamate and Acetylcarbromal reportedly do not. Reserpine will also increase the effective hypnotic response to barbiturates and the other hypnotics.

In many of your patients, treatment with these psychotropic compounds may result in sleep. Relief of anxiety may have been the hypnosis-initiating factor. A patient who is in severe pain and has been sleepless for many hours will fall asleep when morphine is injected, but this cannot force us to classify morphine as a hypnotic. Any subdivision of the group of centrally acting drugs must be such so as to include ataraxics as a class separate from anesthetics, analgesics, and hypnotics.

An anti-emetic response of animals and patients was the text of the initial reports of chlorpromazine. This effect is due to the decrease in activity of the chemoreceptor zone, a neural mechanism located superficially in the medulla in the floor of the fourth ventricle. This trigger zone is sensitive to many circulatory chemicals (apomorphine, morphine, i.v. copper sulfate, lanatoside C, hydergine) and if it is stimulated by these chemical agents there is in turn a stimulation of the reticular vomiting center which is more deeply located. The medullary vomiting center itself may be directly activated by afferents from the stomach and other parts of the body.

The phenothiazine drugs (chlorpromazine, promazine, proclorperazine) in therapeutic doses will inhibit the chemoreceptor trigger zone and in larger doses may have a depressant action directly on the reticular vomiting center itself. The other agents mentioned in this paper have little or no direct action on the vomiting or trigger zones. Emotional calmness initiated by many central sedatives may non-specifically aid in reduction of nausea and vomiting.

Vomiting may be a desirable warning sign of a level of toxicity of various drugs such as digitalis. For this reason, the phenothiazines should be used cautiously in a digitalized patient. They have their best use in the treatment of digitalis overdosage *after* the digitalis has been withdrawn.

Analgesia is not a property of any of these ataraxics, but chlorpromazine particularly has been effective in patients with severe prolonged pain. The threshold to pain-stimuli, in this case, is not increased but there is evolved in the patient a state of indifference to, rather than an absence of pain.

Potentiation of analgesic agents has been reported for many of the ataractic chemicals. The non-analgesic property of the tranquilizing agents indicates that this is a true potentiation and not an effect of summation. Such a potentiation may

be very desirable and useful in relieving pain in patients who are no longer aided by hypertherapeutic dosages of analgesics. This is also a useful property in initiating analgesic therapy in allowing one to use lower doses of narcotics or to use less potent analgesics. The myriad indications of such an increase in effectiveness of the concomitant analgesics may be more readily seen by the reader who may have many specific patients or disease processes in mind.

Chlorpromazine and promazine notably do potentiate the effects of narcotic analgesics. The actual degree of potentiation is debatable and may vary considerably with the type of pain and the individual's pain-thresholds. But the suggested alteration in the dosage of the accompanying central depressant, when chlorpromazine, promazine and proclorperazine are used, is usually such that the dosage of sedatives, narcotics and opiates should be reduced to one-quarter or one-half when these ataraxics are employed. This reduction is only a suggested mid-point from which each patient should be titrated, *i.e.* increase or decrease the dosage until optimal responses are effected.

The skeletal-muscle relaxing properties of meprobamate has found use in the treatment of muscle soreness and tenderness, but the success in such therapy has been due to the interneuronal effect as well as reduction of irritability and restlessness, rather than a true analgesic property.

The general anesthetics and centrally acting muscle relaxants are also potentiated by the phenothiazines. The phenothiazines, in combination with alcohol, will cause a modification of the usual responses to ethanol. The excitement stage of alcohol depression is modified or eliminated and the subject passes directly into the primary depressant or comatose stage which is potentiated markedly.

Animal experimentation has shown that reserpine and chlorpromazine will potentiate the depression induced by ethanol and hexobarbital.[10] This potentiation is not due to any rate of metabolism or uptake by the brain. Reserpine and chlorpromazine presumably increase the depressant response to ethanol and hexobarbital by way of increasing the sensitivity of the central nervous system to these central depressants.

Many of the toxicological responses of patients to these drugs are manifestations of the central effects of these drugs and will be mentioned later.

CARDIOVASCULAR EFFECTS:

Following the intravenous injection of chlorpromazine (0.1 to 5 mg./Kg) into dogs, there occurs a marked hypotension of short duration. This is a larger dosage range than is administered to humans, but this experimentation has served to illustrate the mode of action of the hypotension of chlorpromazine. It is a direct vasodilatory effect and is not inhibited by vagal stimulation nor by the injection of parasympathomimetic drugs. Atropine also fails to alter the fall in blood pressure. This indicates that it is not any functional alteration of the parasympathetic division of the autonomic nervous system. In the same type of animal-experiment the pressor effect of epinephrine is blocked and reversed, while the depressor action of histamine is somewhat reduced indicating that this drug has an adrenergic blocking activity and a weak antihistaminic effect as well.

Proclorperazine has approximately one-half of this adrenolytic activity of chlorpromazine and like chlorpromazine causes little or no parasympathetic effects and has no ganglionic blocking activity. The reduction of systolic blood pressure is slight, if it is compared with that produced by chlorpromazine and/or promazine.

In clinical observations the most profound cardiovascular effect with chlorpromazine and promazine is that of a transitory postural hypotension. This is not observed in many patients who are kept at rest for a period after the initial dosage. If such a hypotensive state is effected, the vasopressor drug, norepinephrine, is the treatment of choice. Epinephrine is not to be used because these phenothiazines may reverse the pressor activity of epinephrine, causing even a greater decrease in systolic blood pressure instead of elevating it.

Tachycardia has been consistently reported to occur shortly after the administration of chlorpromazine. It is generally believed that this cardiac response of the patient is secondary to, and compensary for, the vasodilatory action of chlorpromazine.

Reserpine, in contrast, is neither sympathetic nor parasympathetic in peripheral nature, but from a central site does act on the cardiovascular system, causing a bradycardia and a hypotension. It has been used clinically as an antihypertensive alone as well as in combination with other antihypertensive agents, such as Apresoline. Its anti-

hypertensive action is probably a result of activity at the hypothalmus where integration of autonomic functions occurs and at this site may cause an autonomic imbalance.

Hydroxyzine, meprobamate and acetylcarbromal evidently do not usually exert any effect on the blood pressure level. Any consistent reduction in blood pressure by these drugs would indicate a psychogenic hypertensive state in the pretreated patient.

Benactyzine, which has anticholinergic and antihistaminic activity will enhance markedly the action of epinephrine on blood pressure and decreases the $L.D._{50}$ of epinephrine in mice.[5]

SIDE EFFECTS AND TOXICITY

It has been almost traditional for the medical and allied professions to view new types of therapy with a great amount of skepticism and caution. These attitudes evidently were overpowered by the ataractic onrush. It should not be surprising, therefore, that the journals are commencing to carry many more accounts of untoward effects of these drugs. The toxicity of most of these agents is beginning to catch up with their clinical efficacy. With any new compound it is anticipated that there will be some untoward effects. The claims of "no toxic effects" ascribed to newer ataraxics are due to prematurity of the statements and possibly to limited investigations of clinical and pharmacological effects of these drugs. The reported lack of toxicity does not excuse the indiscriminate use by the medical profession that has resulted.

Many of the later reports of toxicity of these compounds have been individual case reports which may be descriptions of personal idiosyncrasies. Also, the possibility of involvement of adjunctive medication cannot be discounted. It is difficult to evaluate these many clinical findings and decide whether or not they can be classified as an untoward effect of the involved drug.

Drowsiness certainly occurs consistently enough to be recognized as an undesirable side-effect of these drugs. The hypotensive character of the phenothiazines is equally as reproducible.

Chlorpromazine hinders two physiological defense mechanisms against cold *viz.* vasocontriction and shivering. It is usually an effective vasodilator, but it does not as consistently abolish shivering. A transient hypothermia may result from these actions. A central action has been implicated in the disruption of the temperature regulation, but the peripheral vasodilation appears to be predominant. Toxicity of chlorpromazine may be augmented by extreme changes of environmental temperature.

Goldman has studied carefully 1,227 patients who received chlorpromazine and has reported the incidence of many side-effects of this drug in his survey.[11] The patients in this group received as little as 75 and as much as 1500 mgm/day with a median dosage of 600 mgm/day. In this study he reports that parkinsonism, dermatological effects (eruption, edema, photosensitivity), infections, convulsions and dystonia were the most commonly occurring side reactions that he observed. In another but smaller group (442) that received reserpine in dosages of from 3 to 15 mgm/day (median 6 mgm/day), there were no reported occurrences of photosensitivity nor of dystonia. Evidently these two untoward symptoms are peculiar to chlorpromazine and possibly to the derivatives of phenothiazine. The other above-mentioned side-effects also occurred under reserpine therapy.

Jaundice is a sign that has been associated with chlorpromazine therapy. The jaundice resembles that which is caused by extrahepatic obstruction, as suggested by laboratory tests. The incidence of such jaundice has been studied from data collected from various investigators throughout the world.[12] The results indicate that two variables, dosage and duration of therapy, may influence the rate of occurrence of this disease. If dosages involved were high, *i.e.* from 200 to 3400 mgm/day and over a long period, 1 to 14 months, there was an incidence of 1.4% of jaundice (total 7,599 patients). In patients receiving low doses (30 to 150 mgm/day) for a week or longer the incidence was 0.8%. In patients (2,229) receiving low doses in short term therapy (25-300 mgm/day for 1 to 5 days) no jaundice appeared.

A report by Friedman and Marmelzat on the adverse effects of meprobamate described cutaneous, muscular, gastrointestinal and cerebral effects.[13] The cutaneous dermatological side effects were chiefly itching purpuric lesions which usually appeared first in the pelvic girdle and genitalia. A temporary ocular palsy was reported in one patient and a severe diarrhea in another. In three patients that they observed there was extreme excitement rather than tranquilization. After withdrawal of the drug this excitatory

state was reproducible with re-institution of meprobamate therapy.

It may appear that the earlier ataraxics are the most toxic but the great number of publications concerning them, as well as the longer time for their evaluation, may comparatively exaggerate their side effects. The paucity of reports of any toxic effects of the newest ataraxics is, no doubt, because it is too soon.

There have been few studies conducted concerning the comparative toxicity of the ataraxics. Such studies would not be very informative. They might vary according to animal species, route of injection and age and sex of animal. This could not be readily applied to human therapeutics, except by conjecture. Values have been given for ratio of lethal dose to therapeutic dose via various routes of administration, and animal experimentations have indicated that the therapeutic ratio of most ataraxics is quite high. There have been reported attempts at suicide with dosages that have been high multiples of the therapeutic dosages with subsequent recovery of the subjects. These acute toxicity reports are fragmentary and indicate that, acutely, the drugs are relatively non-toxic as claimed. However, chronic toxicity studies might indicate a different therapeutic range than has been reported.

HABITUATION AND ADDICTION

Of course, it has not be possible to classify these drugs as addictive using the present standards for such a classification. The definition of addiction and the qualifying characteristics of this state have been made with morphine and other narcotics in mind. It has been reported that with most of these ataractic agents there are usually no evident withdrawal symptoms when cessation of therapy is initiated. Rather than the specific physiological absence of the drug, it is a return to the pre-treatment anxiety state which is stressful to the patient. Lemere has challenged the classification of meprobamate as a non-habit-forming drug and his survey of a small number of patients has indicated that this drug may be considered as habit-forming.[14] He describes a patient who had been taking excessive amounts of meprobamate (6.4 Gm. daily for one month) who had a severe convulsion 10 hours after meprobamate was withdrawn. He also describes patients under the influence of 2.4 Gm. or more per day who demonstrated signs of an alcohol-like intoxication.

Tolerance is usually quite minimal, although Lemere[14] has also described several patients who had to take increasing amounts of this drug in order to continue an effective therapeutic state.

A true physiological dependence has not been described for any of the ataraxics but can one say that a patient who cannot face anxieties unless he is ataractized is dependent on a drug? It is not too unlike the morphine-addict who has had to revert to a narcotic state in order to leave his anxiety-prone environment.

It is too early to make frank statements as regards the habit-forming or addictive properties of this rapidly expanding list of ataraxics. But we should not scoff at the few "brave souls" who have suggested such properties, as many of us did when it was first proposed that the barbiturates might have addictive properties.

DISCUSSION

From the effluent of 10,000 or more publications concerning the ataraxics, it is not easy to coordinate and correlate the reported findings. This ataractic deluge has made it difficult for the researcher or practitioner to be uniformly well informed of the latest progress or regress in psychopharmacology.

It is very evident that these new drugs are chemically unlike. The difference in pharmacological response to them may have been less obvious. For instance, in this group of drugs we have adrenolytics as well as anticholinergic drugs. The side effects of such compounds, then should be well anticipated if the type of induced autonomic imbalance is also understood. The antihistaminic nature of many of them should indicate the possible quasi-hypnotic property of many antihistaminics. The paradoxical convulsive state like that produced by overdosage of certain antihistaminics has been described in reports concerning effects on animals of toxic as well as therapeutic doses of the ataraxics.

The potentiation of narcotic and other analgesics by certain of the ataraxics may be dangerous if the prescriber is not always fully aware of this property. Contrarily, it may be an advantage to the practitioner who wishes to use less of the more potent analgesic compounds. We can also readily see that it might be desirable for the anesthesiologist to effect a surgical stage of anesthesia with a smaller than usual concentration of the anesthetic agent.

Stimulated by hearsay and buffered by sensational lay publications, patients have been approaching the physician with their self-diagnosis completed and have outlined the expected ataractic regimen to the physician. It may be less painful for the physician to pacify such demands by compromise, but it fails to alleviate or cure the illness which the patient has possibly brought to him. Patient-doctor relationships are still essential for the treatment of the patients with behavioural pathology and it will be quite dangerous for the medical practitioner to attempt to "mail order" psychosomatize their troubled patients.

Tensions, anxieties and other stress factors may be essential for the development of a mature individual who can then adjust better to this stressful environment. Temporary relief from anxiety may in itself produce an obliquity of the personality. Is a person, then, who is under the influence of ataraxics as capable to drive an automobile, airplane or locomotive as one who must face the urgencies of his duties without a "reticular crutch"? The "don't give a damn pills" may be essential for many individuals, but the most skilled performers of certain precarious duties are such because they *do* give a damn about the strains, dangers and possible consequence of their duties. Alteration in conditioned reflexes or ability to make decisions may be even dangerous to many of our everyday nonprecarious functions.

The final test of any drug's value is in its capacity to alter the physiology of human patients. In this psychopharmacological field of endeavor there has not been any real exacting means of testing their worth by utilizing experimental animals. Anxiety, tensions, confusion, and depressive states may be mimicked in the lower animal but a schizophrenic state with measurable psychosis cannot be evaluated in animals as well as in man as can the adrenergic-blocking action of dibenzylline or the adreno-cortical stimulatory properties of ACTH. Perhaps, when and if the abnormal processes of mentation are transcribed to specific biochemical alterations, laboratory evaluation may be possible.

On the other hand, in an attempt to clinically evaluate these compounds, many reports have appeared in the journals in which ward-behavior and management of the patient is emphasized and statistically analyzed. These reports bear the connotation that the final evaluation of such drugs depends on the manageability of the patient and the resultant general welfare of the hospital staff. It is, of course, a great boon to the psychiatric-ward personnel to effect a more manageable ward and making it easier for the doctor, nurse, etc., is fine, but is the ultimum in chemotherapy primarily to make improvements in the doctor's life and well being? It reminds one of the situation Ogden Nash describes in the ditty:

"She took those pills from the pill-concoctor
and
Isabel calmly cured the doctor".

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Myasthenia—A Rare Disease?

J. E. TETHER, M.D.*

Indianapolis

MYASTHENIA GRAVIS was a rare medical curosity until 1934,[1, 2] when the remarkable therapeutic and diagnostic effect of neostigmine** on this disease was reported. Since then, diagnostic rates have shown a progressive increase. This trend has been given even greater impetus by improved methods of testing such as provocative tests with curare[3] and quinine[4] and by the intravenous use of neostigmine[5] and Tensilon[6]***. By 1952, sufficient cases had accumulated to warrant the founding of a Myasthenia Gravis Foundation with headquarters at the New York Academy of Medicine, 2 East 103rd Street, New York City, New York. In 1954, this organization sponsored an international conference, the proceedings of which were published as a symposium in the American Journal of Medicine, November, 1955.

Myasthenia is a fluctuating condition of easy fatigability of voluntary muscle, aggravated by exertion, emotion and infection and relieved by rest and cholinergic drugs. It has become increasingly evident that its cause is inability to metabolize or excrete a fatigue product which then blocks acetylcholine activity at the neuromuscular junction in a curare-like fashion. It is, therefore, not inconceivable that myasthenia of varying degrees could be a common cause of fatigue in many, otherwise, normal individuals.

About nine years ago, this author first became aware of the existence of a mild form of myasthenia. Patients with this less severe form of the condition did not have all of the classical symptoms and signs of myasthenia gravis. Nevertheless, they showed typical easy fatigability of voluntary muscle, aggravated diagnostically by one-tenth of a minimal curarizing dose of d-tubocurarine, and unequivocally improved by neostigmine or Tensilon intravenously.

As of January, 1957, our series includes 676 cases of myasthenia of all degrees. All cases included satisfy the diagnostic criteria for myasthenia. However, the range of severity is extremely wide as 297 fall in the moderately severe to severe category while 379 range from moderate to mild to minimal. Thus, it would seem that, as is the case with diabetes and hyperthyroidism, myasthenia may be present in any degree. If this were so, there would be many mild cases for every severe one. Because of this situation, serious consideration has been given to elimination of the term "gravis," which means "grave, or severe".[7]

A comparison, in tabular form, between the symptoms of mild and severe myasthenia, show clearly that the difference is mainly one of degree (Table I). It will be noted that mild myasthenia, allowing weight-bearing, may cause defects in posture which in turn cause aching in the neck, back, arms and legs.[8] In severe myasthenia, this is absent until sufficient medication is given to allow weight-bearing. It may then disappear if dosage is raised.

In either mild or severe myasthenia, all symptoms are not usually present in every patient and they show wide variation punctuated by remissions or relapses in most cases. It has become apparent to this author that myasthenia is not usually a progressive disease. Therefore, one seldom sees a mild case progress to the severe degree.

When a patient's symptom-pattern leads a physician to suspect myasthenia, the simplest and safest procedure is an oral therapeutic test with one of the cholinergic drugs. The author prefers Mestinon[9, 10] because of its milder side-effects.

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* Assistant Professor of Neurology, Indiana University Medical Center.

** "Prostigmin", Hoffmann-La Roche.

*** "Tensilon" (edrophonium), Hoffmann-La Roche.

TABLE I

A COMPARISON IN SYMPTOMATOLOGY IN MILD AND SEVERE MYASTHENIA

Muscles Involved	Mild Myasthenia	Severe Myasthenia
Eyes — Lid	Slight ptosis, often unilateral.	Severe ptosis to point of lid closure—often unilateral.
Eyes — Extraocular	A light blurring of vision; itching and burning of eyes.	Severe blurring; diplopia; itching, burning, watering eyes.
Facial	Sad, tired expression.	Sad, tired expression; peculiar "snarl-like" smile.
Jaw	Jaw fatigue on chewing gum or tough meat.	Jaw fatigue on any chewing; inability to close mouth at times.
Tongue	Slight slurring of speech; sensation of "thick tongue"	Dysarthria to point of unintelligible speech; inability to protrude tongue.
Pharyngeal	Slight difficulty in swallowing with occasional choking.	Dysphagia with regurgitation of fluids through nose and mouth.
Neck	Tiredness, tightness or stiffness, and aching in back of neck.	Inability to hold head erect; no aching or stiffness however.
Arms	Fatigue and aching on reaching up as with care of hair.	Inability to lift arms above shoulder level more than a few times.
Hands	Inability to remove jar lids or wring out clothes; dropping of heavy articles. Hands tire on repetitive motion.	Inability to grip and carry light articles, or write with pen.
Chest	"Heaviness" in chest and slight breathlessness.	Dyspnea on slightest exertion; occasional cessation of respiration requiring respirator.
Back	Tiredness and aching in interscapular & lumbar areas; poor posture of which patient may be conscious but unable to remedy.	Weakness, preventing erect posture for any period of time; no aching or poor posture until medication allows weight bearing.
Abdominal & Perineal	Constipation; abdominal ptosis.	Constipation; abdominal ptosis.
Legs	Leg fatigue on stair climbing; legache —"deep, dull, tired ache"; "restless legs".	Legs may collapse, causing falls; no pain unless medication allows weight bearing.
Feet	Tired, aching feet; feet "slide down in shoes"; difficulty getting fit in shoes.	Weak feet; no aching unless medication allows weight bearing.

Mestinon bromide is available as a double-scored 60 milligram tablet. One quarter tablet is given three times daily after meals. Every two days, another quarter tablet is added after each meal until the dose reaches two tablets after meals or until a slight reaction occurs. Side-effects of Mestinon usually consist of slight muscle fasciculations of the eyelids, face, or tongue, salivation, sweating, mild abdominal cramps and diarrhea. The patient is warned of these and is told to take atropine sulfate, 0.6 milligrams (1/100 gr.) by mouth every 15 minutes until they disappear or until a dry mouth occurs. Should a severe reaction occur, including vomiting, which is rarely

observed, this dose of atropine should be doubled or should be given intravenously and repeated every 15 minutes until a dry mouth occurs.

Should the patient have no improvement before side-effects are reached, myasthenia is unlikely. If no side-effects or improvements occur on two tablets after meals, the dose should be increased until either one or the other appears. Tolerance to this amount of Mestinon is suggestive of myasthenia.

Improvement on oral Mestinon, or other cholinergic drugs, is only presumptive evidence of myasthenia and confirmation with one of the intravenuos tests should then be obtained.[3, 4, 5, 6]

Treatment of myasthenia, for many years, was practically confined to the use of neostigmine in 15 milligram tablets by mouth, and by injection when necessary. In the past few years, Mestinon,[9, 10] Mytelase (Win 8077 or Mysuran)[11] and prolonged action tablets of neostigmine and Mestinon[12, 13] have proved more effective in most cases. As myasthenia is so variable, it is necessary for each patient to learn to adjust his medication to his needs; in other words, he should learn "demand dosage". Medication far in excess of requirements, a situation which may occur in the more severe cases taking tremendous doses, may fail to give the usual side-effects. Instead, extreme weakness may occur, with excess secretions, choking, and difficult breathing. This overdosage weakness has been called "cholinergic crisis".[14] In such a case, if more cholinergic drug is taken by a desperate patient, or is given by his physician, death may result. When in doubt, atropine sulfate, 1.2 milligrams (1/50 gr.) or more should be given intravenously and repeated every 15 minutes until improvement or a dry mouth and rapid pulse occurs. Tensilon[6, 14] may also be used to differentiate a cholinergic crisis from a true myasthenic crisis.

Some severe cases have a good response and tolerance to tremendous doses of cholinergic drugs.[15] Others, the "brittle" type, have a poor response and tolerance to much smaller doses. In general, however, as in treatment of diabetes with insulin, the dosage varies directly with the degree of severity.

Before the advent of cholinergic drugs, about 90 per cent of severe myasthenics died. Now, the mortality rate of the severe type is about 10 per cent. As the disease is not progressive in most cases, the mortality in mild to moderate cases is practically zero.

Fortunately, patients seldom, if ever, become refractory to cholinergic drugs, and prolonged heavy dosage in many cases has, as yet, failed to produce a single instance of proved organic toxicity.

Fatigue is one of the most frequent complaints any physician hears, yet it is seldom diagnosed or treated effectively. As myasthenia may be a common cause of fatigue and as it is relatively easy to diagnose and treat, a high index of suspicion regarding this condition should prove valuable to any practicing physician.

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The Journal
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Devoted to the interests of the medical profession of Indiana

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COMMITTEE REPORTS

MUCH OF THE WORK of an association such as the Indiana State Medical Association is accomplished by committees. The effectiveness of committee work is often dependent on the ability of the association to acquaint the membership with the results of committee deliberations. Unpublicized recommendations are useless and sterile.

There is more to the problem than simple publication of committee reports. The big idea is to provide coverage of committee activities when the news is fresh; and also to publish it in such a way that it will be read.

Dr. Elton Clarke, President of ISMA, some of the committee chairmen, and THE JOURNAL staff have been considering ways and means of presenting the results of committee work on a current basis. The plan is to publicize the deliberations and recommendations at a time and in such a way that they can be acted upon.

It has been customary to publish a report for each committee immediately prior to the annual convention—at the end of the working year—and to include these reports in a reference book for the House of Delegates. This custom will be continued. However it does not give sufficient coverage to make all committee programs effective. What is needed is news from the committees throughout the year, and especially during the early part of the fiscal year, when the committee programs are first established.

In the past much good committee work actually has been wasted simply because the news of it was not transmitted to the membership until the last of the year. The new system is designed to get the committee reports out to the doctors while they are still fresh.

Dr. Clarke has grouped all the committees whose main function is in the field of preventive medicine and public health. The group is designated as the Commission of Public Health Agencies. Dr. Lall Montgomery of Muncie is chair-

man, and Dr. Ted Hayes of Muncie is vice-chairman.

This one group of committees is planning to have a written report for publication on a monthly basis. These will probably appear as Committee Pages. It is hoped that other committees, which have a message, will avail themselves of THE JOURNAL, and submit special reports whenever their work will be enhanced and made more effective by immediate publicity.

A welcome by-product of current reports might possibly be the simplification and shortening of the annual reports which are written for the convention. In many instances in the past the annual reports have necessarily been long, and since they are long, are not read by many of the members. Interim reports through the year will reach more doctors, and will make for short summary type annual reports.

CLINICAL MEMORANDA ON ECONOMIC POISONS

THE National Agricultural Chemicals Association has reproduced the most recent revision of "Clinical Memoranda on Economic Poisons" and is making the booklet available to physicians, hospitals and poison information centers. The text has been prepared by the United States Public Health Service, and summarizes clinical, toxologic and therapeutic information on insecticides and rodenticides. Copies may be obtained by addressing the National Agricultural Chemicals Association at 1145 19th St., N. W., Washington, 6, D. C.

MEDICAL ASPECTS OF AUTO ACCIDENT PREVENTION

THE TWO GENERAL CONCLUSIONS of a recent conference on automobile accident prevention were that the medical aspects of the problem were amazingly complex, and that considerable research would be required before definite recommendations could be formulated.

The December 15 issue of the New York State Journal of Medicine published the proceedings of a symposium on the medical aspects of motor vehicle accident prevention, held at New York University last May under the chairmanship of Dr. George E. Armstrong.

The conference was attended by 125 physicians, psychologists, traffic safety specialists and motor vehicle administrators from all over the country. In order to make the most efficient use of symposium time, the participants were furnished with a list of fundamental discussion questions and a number of items of medical and non-medical literature for prior study.

"Driver attitudes and personality characteristics have a major role in the causation of traffic accidents and the research in this area must be continued and intensified," the conference report said. The importance of the mental attitude of a driver, in contrast to his physical condition, is emphasized by the apparent good driving record of paraplegics and quadriplegics.

It was recommended that a study be made of the driving and safety records of individuals whom the Veterans Administration has furnished automobiles especially fitted for use by veterans with orthopedic disabilities.

It is possible that the statistics will show that physically handicapped drivers have the best records. Howard Rusk summarized this portion of the problem by remarking that one of the questions that needs to be considered is "What does an automobile do to the average individual to change his whole concept of manners?"

The conference systematically discussed all the medical aspects. These were divided into three groups: Psychiatric-Psychologic, Organic Medical, and Drug and Chemical Aspects. The organic groups were subdivided into cardiovascular, neurologic, ophthalmologic, diabetic, geriatric, and orthopedic.

Throughout all the discussions appeared the need for research. For instance, there is some evidence to indicate that deaf-mute drivers have better records than do the drivers who are normal in this respect. There is also some indication that

the standard driver tests which measure ability for depth perception and reaction time may not be critical of an individual's driving ability.

Altogether the conference formulated 15 major recommendations for research into various medical aspects of the question. There were many minor points which were discovered during the symposium, but which were not listed in the summary.

Very little investigative work has been done in the past. One of the most important findings of the symposium was the demonstration of how meager the store of basic facts on the subject actually is. The conferees pointed out that, in consideration of the hundreds of millions of dollars spent on highway construction, and of the hundreds of millions of dollars of property damage and thousands of lives that are lost in accidents, a fairly sizable sum could reasonably be spent in obtaining the information necessary to pick out the safe drivers and weed out the unsafe ones.

Letter to the Editor:

American Medical Association

535 NORTH DEARBORN STREET . CHICAGO 10, ILLINOIS

February 14, 1957

Frank B. Ramsey, M.D., Editor
The Journal of the Indiana State Medical Association
201 Hume Mansur Building
Indianapolis 4, Indiana

Dear Frank:

Best congratulations on the Golden Anniversary number of The Journal and thanks for the story telling of my new job.

I enjoyed so much your editorial and your article on "The Journal Has Lived in an Era of Change and of Unequalled Progress." Doctor Peyton's article in regard to the doctor's duty as a citizen is just as good now as when it appeared fifty years ago.

It was good to read Dr. Jane Ketcham's and Dr. Goethe Link's interesting and humorous accounts from their actual practice.

I had the privilege of serving with Dr. Albert E. Bulson, Jr. and Dr. E. M. Shanklin when they were editors of The Journal. Under them The Journal rose to be one of the outstanding state medical association publications in the country. Both Doctor Bulson and Doctor Shanklin were true Hoosier individualists and The Journal largely during the editorship of each reflected their personalities. Each had his own style and would not hesitate to use his position as Editor to express his own views. Doctor Bulson was unusually adept at writing editorials. Doctor Shanklin introduced the editorial short and interwove his thinking on medical subjects with vignettes telling of the beauties of his beloved Wild Cat Creek in the Spring and Fall. His notes on personalities which he collected at each state meeting were a feature of each post-convention issue of The Journal. Doctor Bulson was one of the pioneer battlers against socialized medicine. He early warned the profession against the dangers of government control.

Thanks again and congratulations on The Journal.

Sincerely,
Tom Hendricks
Field Director

TAH:sc

The President's Page

A TRIBUTE TO OUR WOMAN'S AUXILIARY

"We ask Thee, O God of Heaven and Earth, to keep us, the helpmates of those whose life work is the ministry of healing.

"May we learn to know that their sacrifice is not small, but motivates their lives in service to others. Help us to have unselfish, understanding hearts.

"Keep us patient and forbearing, and as it is given to us to keep the hearth of our home fires swept clean of pettiness, so give us strength to be kind and generous in thought at all times."

THESE BEAUTIFUL WORDS of the Auxiliary Collect, used by special permission here, illustrate very well the basic aim and purpose of the Woman's Auxiliary to the Indiana State Medical Association. The activities of this most helpful and beneficent organization have grown tremendously. Now, they are interested and working in practically all of the organizational projects which the men's organization tries to further, and in several projects peculiarly their own.

The field of Public Relations, for example, is an ideal garden spot for Auxiliary activities. Members give much time and assistance to community projects such as Community Chest, health drives, blood bank and civil defense. The conducting of Science Fairs in various localities opens up practically unlimited vistas of opportunity. Health Days are being held for better Medical Public Relations. Already these have been held at Seymour, Lafayette and Lowell, and others are being planned.

Our Committee on Public Policy and Legislation, which is doing such important and valuable work this year with both the national Congress and the Indiana General Assembly in session, needs and receives their help.

The A.M.E.F. Committee has attracted much attention, as is shown by Mrs. Ethel Gastineau being made Chairman of the national committee and later Third Vice-President of the National Auxiliary.

The Rural and School Health Committee has been very active, and has been working in close association with the I.S.M.A. Committee on Rural Health.

Nurse Recruitment work is very important in these days of nurse shortages, and is a type of work especially suited to women's talents.

Gaining subscriptions for the magazine, Today's Health, has been an important field of activity.

Safety is the new field which is being stressed by the Auxiliary this year,

and the chairman of this important committee has organized all the county safety chairmen into one organization.

All of these activities and much more are chronicled in the admirable monthly publication, "Hoosier Doctor's Wife", Mrs. Jean Green, Editor.

For many years the women have been furnishing their own entertainment at our state conventions, but this year were granted an allowance by the Executive or Budget Committee for this and other needful expenses of their organization. The Executive Committee of the I.S.M.A. is the advisory committee of the Auxiliary, which tends to correlate the activities of the two organizations, and any new contemplated projects are first cleared with this body. Dr. Walter L. Portteus is the official advisor at the present time.

The annual House of Delegates meeting is at Richmond on April 25 and 26, 1957.

It is my pleasure to express thanks and appreciation to our Auxiliary for the excellent work it is doing, and the beneficial influence upon the communities in which it serves.

Elton R. Clarke, M.D.

MEDICAL STUDENTS RETURN TO SMALL TOWNS TO PRACTICE

A recent American Medical Association report says that medical students who were born and raised in small communities usually go back to small towns to practice after their graduation.

Also, the report says, graduates whose prior residence was in the smaller communities are less likely to limit their practice to a specialty.

The publicly-supported schools—state or municipal—draw a higher proportion of their students from smaller communities and consequently contribute comparatively more physicians to the smaller communities than do the private schools.

The Woman's Auxiliary

REPORTS TO I.S.M.A.

Auxiliary members are looking forward to our annual House of Delegates meeting to be held at the Leland Hotel in Richmond, April 25-26. We hope you will help us get your wife to attend, because the Richmond Auxiliary is planning a most interesting program, both work-wise and fun-wise. The complete program of activities will appear in both the April JOURNAL and the Spring issue of the Hoosier Doctor's Wife.

Four of my state chairmen have written about their work for the year. Their reports and photographs follow:

PUBLIC RELATIONS

Public relations is a general term used to describe all those consciously planned activities used by an organization to establish a better understanding between that organization and the general public.

Thus, the following salient points are suggestions to the Woman's Auxiliary to the Indiana State Medical Association:

Public education to help laymen understand the functions, policies and aims of the medical profession
Unity in observing this year's motto, "Health is Our Greatest Heritage"
Better Mental Health Education
Lecture Panels given by Doctors before the public
Insurance on a Voluntary Medical Plan
Civil Defense

Rural and School Health
Election interests on local, state and national levels
Local community Salk Polio Immunization Education
American Medical Education Foundation
Today's Health Program
Interest in Community Civic Programs
Our Recruitment of Nurses and Medical Technicians
Noting Safety on the Highways and in the Home
Science Fairs—Medical Exhibit Section and Service.

And as a reminder: The physician's wife as a leader in health fields has a great influence on public opinion and should always remember that she is more often quoted, not as an individual, but as the wife of a physician.

Mrs. Wendell C. Stover, Chairman

RULES COMMITTEE

The Rules Committee functioned for the first time at the 1955 House of Delegates of our Auxiliary. The need was felt for this committee for two primary reasons (1) to forestall hasty action on resolutions from the floor that might be in conflict with the objectives and policy of our parent organization and (2) to study proposed resolutions and/or amendments to the By-Laws to determine if they are compatible with our objectives and for the best interests of the majority of our membership. Our House of Delegates schedule is always a tight one, and by eliminating the possibility of fruitless talk on the floor, it

makes for a smoother meeting and more time for getting acquainted. Three former state presidents and the parliamentarian are members of this committee. The knowledge of past procedures and operation of the By-Laws provides this group with a background that enables them to better evaluate proposals that come before them.

Mrs. Hubert T. Goodman, Chairman

RECRUITMENT

The state recruitment program, in cooperation with the national program, is expanding to include not only nursing but also the allied fields of medicine, such as Medical Technology, Medical Social Work, Physical Therapy, and Occupational Therapy. This expansion has come about through the ever increasing demand for health services and the urgent need for more workers in the fields of health.

A 'team approach' in recruitment is helping to create a broader understanding and awareness of working together for better health—among Auxiliary members, among the students towards whom the program is specifically directed, and among the health career workers themselves.

Each Auxiliary, by stimulating and promoting an interest in its community, and by active participation in recruitment work, such as scholarships, teas, tours of various schools of nursing, panel discussions, and other allied programs, becomes a more effective member of our 'team.'

Mrs. I. S. Hostetter, Chairman

CIVIL DEFENSE

The Civil Defense committee of the Woman's Auxiliary to the Indiana State Medical Association is delegated to stimulate interest in the development of the civil defense programs throughout the country, both against possible enemy attack and natural disasters.

To carry out this program we try to assist each auxiliary by sending suggestions for local plans and projects along with pamphlets, films and lists of wide range topics available in civil defense matters. In certain sections of the state our program has been carried out, in part, with favorable results.

This year we are stressing the participation in First Aid and Home Nursing programs, the stockpiling of supplies in homes, cars and other locations and Mass Feeding and Ground Observance Corps programs. We hope to have 25% of our membership active in some category.

Through the active support of the many capable and efficient women in this organization and with the help and advice of our local medical societies and the Civil Defense offices, we hope to promote the success of our national defense program.

Mrs. Paul L. Stier, Chairman

Julia Tindall

MRS. WILLIAM R. TINDALL, *President*

To Each His Own Dignity*

A. D. DENNISON, JR., M.D.

Indianapolis

RECENTLY it was brought to my attention that a number of men were leaving general practice to return to residencies in the various specialties, not always because of an inner drive to know one subject well rather than know many subjects from a pragmatic point of view, but because of interpersonal professional problems with specialists. It was stated that they are hurt, annoyed and embarrassed by being made to feel inferior, by the usurping of patients by specialists, and by the direct or indirect restriction of the pleasurable challenges in medicine. They sometimes are made to feel like moronic purveyors of fascinating cases to their more gloriously endowed colleagues. For this they get little consideration, brief, late, or no reports at all, and perhaps a fleeting glimpse of their former loyal patient as he or she passes in review through the halls of the specialists. This condemnation of the specialist, and reason for leaving general practice bears consideration of the relationship between the consultant and the attending physician, the relationship between the specialist and the family medical advisor. It seems desirable to review this relationship and put forth those ideals most necessary for the specialist to strive for.

The *summum bonum* of the specialists' repertoire must always be professional ability. It is a wise general practitioner who recognizes this and selects his consultant not on the basis of a competently concocted martini, but because he is a man of good training, great academic knowledge, practical bedside astuteness and mature judgment. In keeping his professional house in order, perhaps the next course for the specialist to follow in smoothing out interpersonal tensions with the general practitioner is the question of availability. One may, not too traumatically, slough off a patient who demands prompt service for his medical problem. But, when a colleague is in trouble and needs immediate help for a serious emergent situation it behooves the specialist to put other prior commitments aside temporarily and face the urgent one with pleasantness and vigor. It is far better to honestly admit that one is "completely covered up" and urge his colleague to get another consultant than to promise help and then delay it until the patient has been placed in great jeopardy and the family physician undeservedly embarrassed.

PROMPT REPORT ESSENTIAL

Undoubtedly, one of the major points of disharmony between the general practitioner and the specialist centers around the lack of faithfulness in submitting reports. Either no report is sent, an inadequate report is sent, or the report is so delayed that the attending physician has been under bombardment by frequent telephone calls and visits from the family wishing to be enlightened as to the final conjoined medical opinion. Protocol in the business world, in the diplomatic world, in the field of education, just as in medicine, demands prompt exchange of ideas. One successful midwestern neurosurgeon has reported to the author his monthly telephone bill which amounts to rather staggering figures as telephone bills go. This has resulted because of his faithfulness and promptness in getting information by telephone to the referring physician wherever he may be located in the midwest. This has also stemmed from providing out-of-city physicians with periodic telephone reports and conversations as to the evolutionary status of the hopital patient.

Leaving the more procedural aspects of the problem which involve personal ability, availability for acute situations and faithfulness of reports, there is an aspect of the interpersonal relationships of all people to each other which

* Presented to the Indiana University Medical School Nu Sigma Nu Chapter, August 28, 1956.

comes up in the professional union of the family physician to the specialist. It is extremely important that the specialist be non-critical in his public and private attitude toward the family physician. This involves the psychologic stresses of the specialist, his own inner needs and problems rather than any specific professional rule or criteria. People are either tolerant through training, through suffering, or through basic understanding of the ways of life, or they are egotistical, hyper-critical or intolerant. The specialist who knows a great deal about a little field may have much to criticize of the manner in which a given case has been handled up to the point he arrived on the scene. On the other hand the general practitioner cannot be expected to understand all the intricacies of cardiology or the various esoteric features of neurosurgery, but he does have a tremendous band of diffuse knowledge ranging over all the specialties. Recently it was the author's experience to have two different general practitioners in one week straighten out medical problems in the children of two highly specialized physicians who were vacationing together. This resulted in good-natured raillery on the part of both general practitioners at the ineptness of the two narrow visioned specialists who couldn't diagnose one of the common exanthemata or efficiently treat a case of acute otitis media.

EACH HAS HIS NICHE

Each man has his place in the coterie of physicians. To each his own dignity; to each his own strength and to each his own weaknesses. Intolerance on medical professional levels is the root of many evils. It may be the basis of deep personal unhappiness.

The satisfactory consultant or specialist must in his relationship to the referring physician perform the function of a teacher. This can be done in corridor conversations but best in the summary and discussion at the end of the dictated consultation. Few of us really enjoy being taught. Even in our school days there was an inner rebellion at having to go to school and have varied assorted information jammed into the cerebral cortex. Therefore the teaching done by the specialists must be subtle, gracious, not as if from a high plane of intellectual attainment, but humbly from his studies and wealth of experience. As stated before, it must be non-judicial and non-critical in nature. The intramural exchange of information between specialists and general practitioners can result in great combined knowledge to both groups. Each has something to offer the other.

BASIC ETHICS

It seems almost unnecessary to mention that the specialist should uphold the general practitioner to the patient and the patient's family. Unguarded remarks, facial expressions, a flicker of the eyebrows, can connote so much and do so much harm. To overtly or occultly criticize the family physician to the patient or his family is not only a breach of the code of ethics of the American Medical Association but it is a breach of good social breeding and conduct. Anyone who indulges in this subtle form of medical hostility deserves to lose his circle of referring physicians and to be relegated to a non-referred practice.

Again it seems unnecessary to warn the young specialist who is coming out into the world of private practice that he must never "steal" a case from the attending physician, the general practitioner, or indeed any of his colleagues. If one has been honored by having his opinion asked, one should support the dignity of that honor by making a good report to the referring physician and returning his case post-haste to him. The economic insecurity and the anxiety of the newly started specialist may make him forget this professional amenity. But by this forgetfulness he starts himself on the road of "behind the back" criticism of his professional conduct and lean years of a non-referred practice in his speciality. No greater honor can accrue to a specialist than to be called upon by his colleagues to render help, advice and support. If this relationship is thrown into jeopardy by poor ethical conduct then he becomes a doctor solely dependent on patient referral and this puts him into the category of being a competitor with the very men who might refer work to him.

CONSULTATION ON CHARGES

In the interest of harmony within the medical family, the specialist is urged to avoid excessive charges. How long can the general practitioner soak up the criticism of the patients who return to him from the specialist with the statement, "He gave me a fine examination and undoubtedly he is a fine physician, but I cannot stand his fees"? When this has happened to the referring

physician a few times he will then have to transfer his loyalty to another specialist in the same field whom he may not think quite as able but who is more realistic about his fees. In turn it is most helpful to the specialist to receive some hint or suggestion from the attending physician as to what the patient can bear in the way of a fee.

This point naturally leads to the next consideration that it is just as important for the specialist to sell himself to the patient as it is to sell himself to the referring physician. How long could a busy general practitioner stand up under this kind of remark constantly coming back to him as he sat with his patients in his consultation room, "He probably is a man of great ability and is of help to you, but I couldn't stand his personality. He wasn't very pleasant and I wouldn't want to go back again"? The referring physician after hearing such comments about the irritable, ugly, hurried, unpleasant personality of a consultant would have to choose a specialist, perhaps less able, but one who possessed tact, warmth, empathy, diplomacy and sincere interest and love for human beings.

It behooves the specialist to sign off a case when it appears medically feasible. Double bills for the patients are sometimes staggering. On the other hand the family physician can help in this decision. His frankness as to the need or lack of need for continued specialty care certainly is invited.

Finally, it seems that the referring physician, besides sincerely wanting concrete help in a case, is entitled to one further consideration. It is extremely important to the good will of this doctor-to-doctor relationship that no major decisions be made by the specialist or consultant without mutual discussion and agreement with the referring physician. How often the general practitioner has reviewed a chart, called upon his patient and found that an additional consultant in another field has been called in without his full knowledge, permission, or choice of selection of the new man introduced into the case. This blatant disregard of one's position in the total care of the patient has resulted in tensions and strains between the two major groups in the field of medicine.

RECIPROCITY WITH PRIDE

To each his own dignity. The specialist, with his increased knowledge in one field, primarily a hospital and office practice, the availability of a good laboratory and radiology department, should be respected for his contributions in detail and decision. To the general practitioner who is "covering the waterfront," facing the day by day challenges of our vast American life, making innumerable decisions in the home, office and in the hospital, guiding serious situations in the right paths for correction, and endeavoring to keep abreast of the new things in obstetrics as well as internal medicine; to him must go his own dignity. There must not be created a sense of inferiority, a lowering of morale, a policy of looking down on a colleague or a critical intolerant attitude. There are few specialists who could emotionally, physically or intellectually stand in the shoes of many of our busy general practitioners today. Pride in our work is the greatest incentive to keep going in a difficult field. This must not be destroyed in either the general practitioner or the specialist.

1005 Hume Mansur Building

Responsibilities of Physicians in Use of X-Rays and Other Ionizing Radiation

INTRODUCTION

1. The United Nations General Assembly, being aware of the problems in public health that are created by the developments of atomic energy, established a Scientific Committee on the Effects of Atomic Radiation. This Committee has considered that one of its most urgent tasks was to collect as much information as possible on the amount of radiation to which man is exposed today, and on the effects of this radiation. Since it has become evident that radiation due to diagnostic radiology and to radio-therapy constitutes a substantial proportion of the total radiation received by the human race, the Committee considers it desirable to draw attention to information that has been obtained on this subject.

2. Modern medicine has contributed to the control of many diseases and has substantially prolonged the span of human life. These results have depended in part on the use of radiation in the detection, diagnosis and treatment of disease. There are, however, few examples of scientific progress that are not attended by some disadvantages, however slight. It is desirable therefore to review objectively the possible present or future consequences of increased irradiation of populations which result from these medical applications of radiation.

GENERAL SURVEY OF THE IRRADIATION OF HUMAN BEINGS

3. Man has always been exposed to some irradiation from natural sources. To this has now been added, as a result of modern discoveries and the applications of ionizing radiation and radioactivity, certain forms of artificial irradiation.

4. *Natural irradiation* is due to:

(1) Cosmic radiation,

(2) "Background" gamma radiation from radioactive substances present locally in the earth, rock or building materials, and from disintegration products of radon in air,

(3) Radiations emitted from natural radioelements such as potassium 40, radium, radon and carbon 14 which are incorporated in the body.

5. The amount of this natural radiation varies with locality, but has been estimated as usually delivering between 70 and 170 mrems per year to the gonads. Of this total, the major contributions are of about 45 per cent from local gamma radiations, 30 per cent from cosmic rays and 20 per cent from body potassium 40.[1]

6. *Artificial irradiation* is derived from:

(1) The contamination of the environment, the atmosphere, or water by radioactive waste from atomic industries or from users of radioelements;

(2) The radioactive fallout, at greater or lesser distances from the source, or radioactivity resulting from the explosion of nuclear devices;

(3) The occupational exposure of certain groups of workers: medical practitioners, radiologists, dentists, nurses, atomic energy workers, uranium or thorium miners, and the industrial or scientific users of radiation generators or radioactive isotopes;

(4) The medical use of X-rays, other ionizing radiations and radioelements in the detection, diagnosis, investigation and treatment of human diseases;

(5) The use of certain devices which emit radiation, such as television receivers, watches with luminous dials, and the X-ray generators used for the purpose of fitting shoes.

[1] From reports sent by India, Sweden, the United Kingdom and the United States of America.

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SEARLE

7. The amount of artificial radiation must vary considerably in different countries and we have inadequate information as to the over-all significance of these factors. In certain countries where estimates have been made, it appears that the greatest gonad irradiation of the population is due to diagnostic radiological procedures, the amount from this source about equalling that from all natural sources in certain instances. The total present contribution from occupational exposure, from the products of atomic industries, from radiotherapy and from the radiating devices mentioned above (paragraph 6, sub-paragraph 5) is likely to be very considerably smaller. That from radioactive fallout to the gonads appears at present to be in the region of 1 per cent of the natural gonad irradiation in most areas.[1]

8. Both the magnitude and the significance of these various sources are under review by the Committee. Since medical irradiation accounts for a substantial if not the major proportion of all artificial exposure, it is important that its magnitude should be known accurately for different countries and circumstances. The possibility of making such an assessment depends upon the help of the medical profession, and particularly on the adequacy and availability of records kept by doctors, dentists and organizations responsible for the use of ionizing radiation.

RADIATION HAZARDS

9. The medical use of radiation is clearly of the utmost value in the prevention, diagnosis, investigation and treatment of human disease, but the possible effects of this irradiation of individuals require examination.

10. Generally speaking, the irradiation of living beings may produce radiobiological effects either on the irradiated individual himself or, through him, on his descendants; the former being termed somatic and the latter genetic effects. Somatic effects vary according to the different organs or tissues affected, and range from slight and reversible disturbances such as cutaneous erythema to the induction of leukemia or of other malignant diseases. The possible reversibility of the somatic effects of radiation received in small doses or at low dose rates encourages the belief that there are permissible doses of radiation which will not cause completely irreversible or significant somatic damage. The threshold for occasional somatic damage may, however, prove to be low. In the case of genetic effects, on the other hand, there may be no threshold. These effects increase with a frequency corresponding to the total amount of radiation received by the germinal tissues, and in the great majority of cases, are adverse.

11. Many other factors complicate the interpretation of radiobiological effects. The differences between whole and partial body radiation, between a single exposure and continuous irradiation, or between the effects of different types of radiation, are still imperfectly understood. Biological differences in the radiosensitivity of various tissues, or of the tissues of people of different age or sex, obviously influence the nature of radiation hazards. It is clear, however, that any radiation of gonads, and any substantial irradiation of other tissues, involve a chance of significant damage which requires assessment.

GENERAL RECOMMENDATIONS

12. The radiological profession, through the International Commission on Radiological Protection,[1] has undertaken a valuable and responsible duty in defining maximum permissible limits of exposure for the main radiation hazards.

13. The establishment of these maximum permissible levels for those who are occupationally exposed to radiation depends on the view that there are doses which, in the light of our present knowledge, do not cause detectable somatic injury in the individual irradiated; and on the consideration that the number of individuals concerned is small enough for the genetic effects on the whole population to be negligible. For the gonads, or for irradiation of the whole body, the levels are such as to exclude doses greater than 0.3 rem in any week or 3.0 rem in any 13 weeks, or a sustained irradiation rate greater than 5 rem per year. These values imply that no total dose of over 50 rem will have been received by the gonads by the age of 30, or of over 200 rem by

[1] According to the reports sent by the United Kingdom and the United States of America.

[1] See the report of the International Commission on Radiological Protection, published in the *British Journal of Radiology*—Supplement 6, of December 1954, and in the *Journal Francais d'electro-radiologie*—No. 10, of October 1955.

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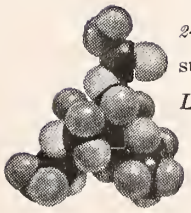

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the whole body by the age of 60, in any occupationally exposed person.[1]

As regards irradiation of the whole population, it is considered prudent to limit the average dose to germinal tissues from artificial sources to the order of magnitude of that received from all natural sources.

14. In considering the extent to which the population is irradiated for medical purposes, it is essentially the genetic hazard which is involved although it seems possible that in certain circumstances somatic injury may occur occasionally after low doses of radiation arise. Otherwise, the relevant dose is that indicating the mean gonad irradiation among the population as a whole up to the end of the average reproductive period.

15. The extent of such genetic irradiation from diagnostic procedures has been found to be equal to at least 100 per cent of all natural radiation in two countries,[2] and that from a third equalled at least 22 per cent of this figure.[3] Even before obtaining more exact values for these and other countries, it is clear that the exposure can be substantial in countries with extensive medical facilities, and that it is essential to consider any ways in which this exposure could be reduced without detriment to the existing or developing value of medical radiology.

16. The Committee is therefore anxious to obtain the help of radiologists in suggesting through appropriate governmental channels any methods by which this total exposure could be reduced and in estimating the amount of reduction that might be expected from any such methods. In particular it would be valuable to know how much the radiation to the gonads could be reduced.

(a) by improved design or shielding of equipment,

(b) by fuller training of any individuals using radiographic or fluoroscopic equipment,

(c) by any local shielding of the gonads that is practicable, especially during abdominal or pelvic examination,

(d) by the use of techniques involving radiography rather than fluoroscopy when full information can be obtained by this means,

(e) by improvement of administrative arrangements designed to obviate unnecessary repetition of identical examinations of the same subject,

(f) by a general study of certain medical conditions such as that of peptic ulcers, to identify the circumstances in which the establishment of a radiological diagnosis has or has not a definite influence upon the treatment or prognosis given.

SUMMARY

1. The Scientific Committee on the Effects of Atomic Radiation established by the United Nations General Assembly accepts the view that the irradiation of human beings, and especially of their germinal tissue, has certain undesirable effects.

2. Information received so far indicates that, in certain countries (Sweden, United Kingdom, United States of America), by far the most important artificial source of such irradiation is the use of radiological methods of diagnosis and that this may be equal in importance to radiation from all natural sources. It is possible that such radiation may be having a significant genetic effect on the population as a whole.

3. The Committee is fully aware of the importance and value of the medical use of radiations but wishes to draw the attention of the medical profession to these facts and to the need for a more accurate estimate of the amount of exposure from this source. The help of the medical profession would be most valuable to make it possible to obtain fuller information on this subject.

4. The Committee would be particularly grateful for information through appropriate governmental channels on ways in which the medical irradiation of the population can be reduced without diminishing the true value of radiology in diagnosis or treatment.

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[1] See the report of the International Commission on Radiological Protection, published in the *British Journal of Radiology*—Supplement 6, of December 1954, and in the *Journal Francais d'electro-radiologie*—No. 10, of October 1955.

[2] Sweden, United States of America.

[3] United Kingdom.

An Important Announcement

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A Private Psychiatric Hospital Offering
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Fifty Years Ago

MEDICAL HISTORY . . . and legislative, too . . . was made in Indiana fifty years ago by the Sixty-Fifth General Assembly. That was the year five major bills were passed which have had great impact on the citizens of the state.

The Registration Act requiring registration of births, deaths, marriages, and contagious diseases was one.

A law to permit the furnishing of free diphtheria antitoxin to the poor upon proper proof was another.

The Pure Food and Drugs Act became effective for the first time. Faint efforts had been made since 1897, when the legislature turned down the first such bill, to establish and enforce an effective food and drug act. The 1907 legislature set up the machinery to get the job done by appropriating $15,000. The Indiana law was the father of the Federal Food and Drug Act.

Action was also taken by the legislators to allow the sterilization of degenerates, specifically naming "confirmed criminals, idiots, rapists and imbeciles".

State tuberculosis hospitals were also established by that General Assembly.

DISEASE RAMPANT

Fifty years ago there was smallpox somewhere in the state every month of the year. Nine deaths occurred from the disease. Thousands of mild, unrecognized cases were known to exist but, in the words of Dr. John Fisk "It takes a thousand years to raise the human family a single notch", and so people were slow to take hold of vaccination and for several years the smallpox scourge continued.

An annual report showed 353 died from diphtheria that year—a decrease from the previous 12 months . . . 1,679 children under 5 died of diarrheal diseases . . . 97 died from scarlet fever . . . 858 typhoid deaths were reported . . . pneumonia took 3,483 lives and tuberculosis 4,297.

. . . FROM THE FILES

That was the year when the Indiana State Medical Association referred to what is now a Committee on Alcoholism as the Committee on Inebriety . . . the state convention was held at French Lick on June 18 and 19 during the hottest week of that year and attendance was cut by the heat and the inaccessibility of French Lick. Doctors in the northern part of the state had to make several changes of cars to reach the vacation spa. . . . an editorial asked "Shall We Charge Clergymen?" and the answer was an unequivocal "yes" . . . county society meetings in many parts of the state presented excellent programs by their own doctors who reported interesting cases they had treated . . . and up in Fort Wayne the newspapers were distressed because the anti-spitting ordinance was not enforced. Editors felt some drastic enforcement was needed to halt the spread of tuberculosis, la grippe and other diseases . . . 25% of the children admitted to asylums and schools for the blind had lost their sight from ophthalmia neonatorum and doctors were endorsing Credé's method to save the sight of newborn.

The Physicians' Directory in 1907 carries professional cards of Dr. Goethe Link and Dr. Homer G. Hamer, both still in practice in Indianapolis. Dr. Link's card announces he does "General and Abdominal Surgery". He was, and is, in the Indiana Pythian building and had "both phones" . . . that meant local and long distance and two phones were actually necessary—the Bell and Independent.

Dr. Hamer was associated with Dr. William N. Wishard in practice limited to genito-urinary diseases. He still practices with Dr. Wishard's son, William N. Wishard, Jr.

Other familiar names appear in the directory of specialists . . . Dr. Maynard A. Austin, Anderson, and Dr. Frank S. Crockett, Lafayette, both past presidents of Indiana State Medical Association, are in that first volume of THE JOURNAL and continued to carry the announcement for many years. Both are in retirement.

—*J. S. G.*

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Indications: Tension, nervousness, anxiety and muscular spasm.

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Cincinnati Sanitarium Changes Name to Honor Psychiatrist

One of the country's oldest private psychiatric hospitals, Cincinnati Sanitarium, has changed its name officially to The Emerson A. North Hospital in honor of a physician who once served a residency there and later became one of Ohio's leading early psychiatrists.

Dr. North was a native of Patriot, Indiana, attended Purdue University for four years and then entered the College of Medicine, University of Cincinnati, where he received his medical degree in 1906. His career on the staff of the University of Cincinnati began in 1925 when he was named a lecturer on psychology. He later became professor of psychiatry and head of the department, a post he held until 1942 when he became professor emeritus. Dr. North died in 1953.

The Emerson A. North Hospital was established as Cincinnati Sanitarium in 1873. Dr. Owen C. Clark is medical director of the hospital which is located at 5642 Hamilton Avenue, Cincinnati, in the College Hill section.

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Surgery of Colon & Rectum, One Week, May 6
General Surgery, One Week, May 13
Surgical Anatomy & Clinical Surgery, Two Weeks, June 17
Treatment of Varicose Veins, Two Days, April 29
Fractures & Traumatic Surgery, Two Weeks, June 17
Gallbladder Surgery, Three Days, June 24
Surgery of Hernia, Three Days, June 27

GYNECOLOGY & OBSTETRICS—
Office & Operative Gynecology, Two Weeks, June 17
Vaginal Approach to Pelvic Surgery, One Week, June 10
General & Surgical Obstetrics, Two Weeks, May 6

MEDICINE—
General Review Course, Two Weeks, April 29
Electrocardiography & Heart Disease, Two-Week Basic Course, July 8
Gastroenterology, Two Weeks, April 15

RADIOLOGY—
Diagnostic X-Ray, Two Weeks, April 29
Clinical Uses of Radioisotopes, Two Weeks, May 6
Radioactive Iodine, One Week, April 1

UROLOGY—
Two-Week Course, April 1
Cystoscopy, Ten Days, by appointment.

PEDIATRICS—
Two-Week General Course, May 13

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

ADDRESS:

REGISTRAR, 707 South Wood Street, Chicago 12, Illinois

Abstracts:

EVALUATION OF CORTISONE IN THE TREATMENT OF CEREBRAL INFARCTION

Dyken, Mark, and White, Philip T., Indianapolis: J.A.M.A. 162:17, Dec. 22, 1956.

Thirty-six patients admitted to a hospital with symptoms of acute cerebral infarction were divided into two groups according to the severity of their symptoms, age, blood pressure, etc. All were given the same general supportive care. Alternate patients in each group were given cortisone in conjunction with potassium and a low sodium diet. (Each was given complete examinations to rule out medical contraindications to the use of cortisone). The remaining patients were given placebo medication.

Treatment was instituted after 24 hours in order to rule out transitory paralyses of other causes.

Thirteen of the 17 who received cortisone died (76%), while 10 of the 19 control patients expired (later extended to 23 of 42 or a mortality of 55%). These results were not statistically significant, however, due to the trend of increased mortality, the investigators felt that they could not subject more patients to cortisone therapy.

William C. Bogan, M.D., South Bend.

MANAGEMENT OF THE PREGNANT CARDIAC

Kaltreiger, D. Frank, West Virginia Med. J. 53:11-15 (Jan. 1957).

The author discusses physiologic changes in pregnancy related to heart disease and outlines principles for care during pregnancy, labor and the puerperium.

Approximately 90 percent of all cardiac patients seen during pregnancy have rheumatic heart disease. The physician caring for a pregnant woman has the opportunity to diagnose chronic illness in the female no other physician has. With better management therapeutic abortion for cardiac indications has markedly declined.

A. Physiology. Vital capacity is increased about 5 percent during pregnancy due to lateral and anteroposterior expansion of the chest wall. Blood volume is increased as high as 45 percent by the 36th week of gestation, thus increasing the demands on the heart for work. Oxygen consumption increases 15 to 25 percent above normal. Cardiac output increases to a maximum around the 28th week, then gradually declines toward term. During labor and the first two days postpartum it increases again and remains elevated for 6 to 8 weeks after delivery.

B. Antepartum Care. Accurate and thorough evaluation of the cardiac status is a prerequisite. Increased amounts of rest and reduction in exercise are indicated. Hemoglobin levels should be maintained over 80 percent. Prompt care of infections and avoidance of stressful situations are essential as these increase cardiac load. The frequency of office visits should be stepped up. Weight should be carefully regulated limiting gain to 15 pounds.

C. Labor and Puerperium. The cardiac patient should be admitted to the hospital one to several weeks prior to the onset of labor. Induction of labor is contraindicated unless for a definite obstetrical indication. This applies equally to Caesarean section. The patient should be observed frequently during labor for signs of early decompensation. Sedation should not be withheld but care exercised to avoid agents which might cause excitement as scopalamine and barbiturates. The author prefers some variety of regional block to general anesthesia for cardiacs. The second stage of labor should be shortened by use of low forceps delivery and episiotomy. Use of oxytocics during the third stage is contraindicated unless there is excessive uterine bleeding. Ambulation is deferred to the fifth or sixth day even in mildest cardiac patients, and longer with more severe cardiac disease. No sterilization procedures should be considered before six to eight weeks postpartum.

David R. Sanderson, M.D., South Bend.

THE DEVELOPMENT OF VISION IN THE CROSS-EYED CHILD

Ellis, George S. and Haik, George M., New Orleans: J. Louisiana State Medical Society 108:12 (Dec. 1956).

The authors state that strabismus affects 1.5% of children in the general population. They classify ocular deviations into several causal groups:

1. Physiological deviation in which the eyes normally cross briefly up until 18 months of age.
2. Pseudo-strabismus in which there are wide epicanthal folds and the eyes appear crossed.
3. Intraocular pathology to produce monocular blindness.
4. Intracranial pathology to produce nerve damage.
5. Errors of refraction, and inward deviation associated with hyperopia, and an outward deviation associated with myopia as a general rule.
6. Muscular dysfunction including congenital muscle anomalies, trauma to muscle or nerves, and loss of muscle tone with general diseases.

Three mechanisms influence the development of normal visual function:

1. Fixation
2. Visual acuity
3. Fusion

The mechanisms develop in this order, each building upon the previous mechanism. At birth the eyes are uncoordinated, but binocular fixation is usually established by three to five months of age. The visual acuity is only about 20/200 at this age, but develops to 20/40 by two years, and to 20/20 by four to six years of age. Fusion develops with the improvements of visual acuity and functions to maintain binocular fixation and sustain the action of the muscles of the two eyes in good coordination. Fusion is usually established from

two to four years of age. Ocular deviation results if fusion is not established. Fusion may be interfered with by any of the above listed factors. The visual effect of deviation depends on the time of its onset: if, after six years of age, diplopia is experienced, as fusion has been established. Prior to six years the image of the deviated eye is suppressed and fusion is lost, but diplopia is avoided. Without fusion, there may be alternate deviation and alternate suppression or there may be monocular deviation with deep suppression, reduction in visual acuity and even loss of central fixation in the deviating eye. Neglect of strabismus may lead to a loss of fusional ability, a loss of vision in one eye, contractions and muscle fibrosis, with limitation of movement and emotional problems.

Therapy depends on early care. One should aim at a functional result with the maintenance of fusion and binocular vision, not just be satisfied with cosmetic improvement. Physicians and parents should be aware of the danger in delay in treatment: also that a spontaneous cure does not occur and that long term observation and management are necessary. If no therapy is started until after six years of age, fusion is lost and suppression established, limiting the result to no more than straight eyes without binocular vision at best. More frequently the deviation can only be partially corrected in these neglected cases by such methods as correction of refractive error, occlusion of the better eye for amblyopia orthoptic training to stimulate fusional ability, or surgery to correct gross deviations.

John R. Cassady, M.D., South Bend.

INDICATIONS FOR ADENOID AND TONSIL REMOVAL IN CHILDREN

Baron, Shirley Harold: Rocky Mountain Medical Journal 53:11 (Nov. 1956).

When infection in tonsils and adenoids or complications associated with such infections outweigh the protective function offered by these organs, tonsils and adenoids should be removed. Age should not be a consideration. Only in rare instances should adenoids be removed without tonsils.

Some of the clear cut indications for removal of adenoids and tonsils consist of: 1) infection, acute or chronic of tonsils, adenoids, sinuses or middle ears; 2) obstruction of airway; 3) conduction deafness. Some contraindications consist of 1) an epidemic of any kind; 2) presence of any acute infection; 3) hematologic disorders.

Removal of tonsils and adenoids in an allergic patient without asthma can precipitate an attack of asthma. Therapy for the allergy must be considered along with the surgery. In the allergic patient there may be a recurrence of lymphoid tissue even after the most thorough technique.

The use of irradiation therapy for the removal of lymphoid tissue in the nasopharynx is questionable since it is of transient value and there is the possible sequela of cancer of the thyroid.

Technical considerations for adenotonsillectomy are discussed. *A. H. Levkoff, M.D., South Bend.*

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1. Personal communication to S.K.F.

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98.7% EFFECTIVE in tropical infections including those complicated by heavy bacterial contamination or multiple parasitisms.[7]

1. Carter, C. H., and Maley, M. C.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 51. 2. Shalowitz, M., and Sarnoff, H. S.: Personal communication. 3. Shubin, M.: Personal communication. 4. La Caille, R. A., and Prigot, A.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 67. 5. Winton, S. S., and Cheserow, E.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 55. 6. Cornbleet, T.: Personal communication. 7. Loughlin, E. H.; Mullin, W. G.; Alcinder, L., and Joseph, A. A.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 63.

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New Manager Named for Indianapolis VA Hospital

Dr. Edward H. Mandell, who has been manager of the Saginaw, Michigan VA hospital since 1953, is being transferred to the VA consolidated hospital in Indianapolis. He will succeed Dr. Earl H. Hare, who is retiring.

Dr. Mandell, a native of New York City, is a thoracic surgeon. He received his medical degree from New York University and Bellevue Medical College in 1924. He was in private practice in New York from 1924 to 1942 when he entered VA as a medical officer in the hospital at Minneapolis. He also served as a lieutenant-colonel with the Army's 110th General Hospital.

Dr. Mandell took his surgical training at the University of Minnesota in 1948. In Indianapolis, he will be manager of the 486-bed general medical and surgical VA hospital and the Cold Spring Road 241-bed hospital for patients with tuberculosis.

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Deaths . . .

Joseph A. Kramer, M.D., 82, who retired from active medical practice in 1946, died February 28 at his home near Windsor in Randolph county. Death was caused by a cerebral hemorrhage.

Dr. Kramer was a native of Ohio and received his medical degree from the University of Louisville in 1908. For 10 years he practiced at Blountsville and Windsor and then became a medical examiner for the Norfolk and Western railroad with headquarters in Columbus, Ohio and Roanoke, Virginia. In 1940 he returned to Windsor, planning to retire. He was called back into service by the railroad during World War II.

Simon J. Young, M.D., 89, died January 13 in his Kendallville home. He had been in practice until three months prior to his death.

Dr. Young was a 1902 graduate of Harvey Medical College, Chicago, and prior to World War I practiced in Valparaiso. He served as a lieutenant-colonel in the U. S. Medical Corps, commanding the base hospital at Camp Gordon, Alabama. Following his separation from service he entered practice as a physician and surgeon in Gary where he became an organizer and first commander of the Gary Memorial Post of American Legion. He was made the post's first life member in 1952. In 1936 Dr. Young moved to Kendallville where he had practiced since.

Dr. Young was a member of Noble County Medical Society, a senior member of Indiana State Medical Association and a member of the American Medical Association and the American College of Surgeons.

Harry Baum, M.D., 53, died January 14 in the Indianapolis Athletic Club where he resided. He had served as cardiologist for the Veterans Administration Regional Office since 1948 when failing eyesight forced him to retire from private practice. He also served as house physician for the Athletic Club.

Dr. Baum was born in Madison, was a graduate of DePauw University and taught science for five years at St. John's Military School at Delafield, Wisconsin before entering Indiana University School of Medicine. He received his degree in medicine in 1937.

Dr. Baum was a member of Indianapolis Medical Society and the Indiana State Medical Association.

Arthur J. Van Winkle, M.D., 69, Valparaiso physician since 1929, died January 20 in Gary Methodist Hospital.

Dr. Van Winkle was a native of Kansas and received his medical degree from Kansas State Medical College in 1926. He served his internship and residency at Gary Methodist Hospital before establishing his practice in Valparaiso. Dr. Van Winkle had served as an examiner for Civil Air Patrol for several years.

He was a member of Porter County Medical Society, the Indiana State and American Medical Associations.

Karl R. Luthy, M.D., Veterans Administration Regional Office physician for the last four years, died January 29 in Methodist Hospital, Indianapolis. He was 67 years old.

Dr. Luthy was a native of Illinois and a graduate of Drake University College of Medicine. He had church and lodge affiliations and was a member of the American Medical Association.

Arnold Utterback, M.D., 71, retired West Terre Haute physician, died February 4 in his home.

He was a native of Kentucky and a graduate of the University of Louisville School of Medicine in 1912. He had been in general practice in Clinton and Vigo counties since that time.

Dr. Utterback was a member of Vigo County

Medical Society, the Indiana State and American Medical Associations.

Raymond Merchant, M.D., 54, died February 9 of a coronary thrombosis in his office in the U.S. Steel Mills in Gary where he had been on the staff since 1945. He was a resident and in general practice in Lake Village.

Dr. Merchant was born in Brook. He received his doctorate in chemistry from the University of Illinois in 1928 and his degree in medicine from Rush Medical College in 1932.

He was a member of Jasper-Newton County Medical Society and the Indiana State Medical Association.

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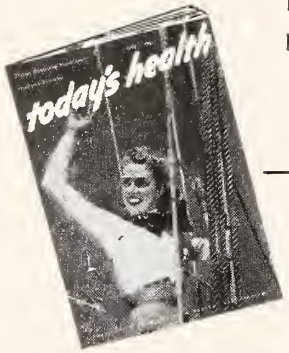

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NEWS NOTES—from State and Nation

Improved and Safer Rabies Vaccine Made Available

A new and safer rabies vaccine, produced in embryonated duck eggs, is now available to physicians and pharmacists. It has been shown in tests to be free of a "paralytic factor" that sometimes has caused paralysis and death during rabies treatment.

Found in conventional rabies vaccines made of rabbit brain tissue, the "paralytic factor" appears to be related to myelin, the covering of brain nerve fibers. The exclusion of myelin from the new vaccine is made possible by the use of duck embryos in processing.

The new vaccine—an inactivated, or killed, virus vaccine—is being manufactured and marketed by Eli Lilly and Company. The result of six years of research and development work, it is the first commercially available vaccine for human use for which the rabies virus is grown in non-nervous tissue. The duck-embryo method was originated by H. M. Powell, Sc.D., of the Lilly biological research division.

Exclusion of the "paralytic factor" from the new vaccine is helpful to the physician in what has been a distressing problem—the decision whether to give a course of inoculations to questionably exposed patients.

The vaccine is "doubly safe" since the virus used in making it is of a strain which is nonvirulent in man. The nonvirulent virus is treated with a chemical which kills the virus but does not interfere with its antigenicity.

Two Changes Made in Indiana Board of Health Personnel

Dr. David F. Stone, Indianapolis, has been appointed director of the Bureau of Local Health Administration of the Indiana State Board of Health.

Dr. Earl H. Hare, formerly administrator of the Veterans Hospital, Indianapolis, succeeds Doctor Stone as new director of the Division of Tuberculosis Control of the Indiana State Board of Health.

Pediatric Postgraduate Course Scheduled at Louisville

The Department of Pediatrics of the University of Louisville in conjunction with the Kentucky State Medical Association and the Kentucky Chapter of the American Academy of Pediatrics, announces its annual pediatric postgraduate course to be held at the Children's

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Hospital, Louisville. This program has been coordinated with the K.S.M.A. Committee on Postgraduate Medical Education.

The course will be given each Tuesday morning beginning April 16 through June 4, from 9:30 a.m. to 12:30 p.m. A slide presentation of rashes seen in pediatrics and the use of the x-ray in pediatric diagnosis, as well as other timely subjects will be presented. At each conference patients of special interest will be discussed.

The registration fee for this course is $30 and credit will be given by the American Academy of General Practice. Any inquiry regarding this course may be made to The Department of Pediatrics, 323 East Chestnut Street, Louisville 2, Kentucky.

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Program Announced for Annual Meeting of Indiana Chapter, ACS

All members of the Indiana State Medical Association have been invited to attend the annual meeting of the Indiana State Chapter of the American College of Surgeons in the Van Orman Hotel, Fort Wayne, on April 24. Those planning to attend should notify Dr. R. Morton Bolman, 717 Broadway, Fort Wayne.

The complete program follows:
(Central Daylight Time)

8:00 a.m. Registration.

8:30 a.m. Welcome to Fellows and Guests: Dr. James Leffel, President, Indianapolis.

8:40 a.m. Invocation: Dr. John W. Meister, First Presbyterian Church, Fort Wayne.

8:45 a.m. Explanation of Program: Dr. R. Morton Bolman, Program Chairman, Fort Wayne.

8:50 a.m. Welcome Address: Dr. Stephen Michaelis, President, Fort Wayne Medical Society.

9:00 a.m. *Injuries of the Ankle:* Richard C. Stauffer, M.D. and Robert F. Kimbrough, M.D., Fort Wayne.

9:10 a.m. *Fractures of the Face:* Sanford C. Snyderman, M.D. and Emil H. Bergendahl, M.D., Fort Wayne.

9.30 a.m. *Carcinoma of the Breast:* Jack E. Pilcher, M.D., Indianapolis.

9:50 a.m. *Hypophysectomy For Metastatic Carcinoma From The Breast:* Bronson S. Ray, M.D., New York.

10:20 a.m. *Acute Cholecystitis:* Cecil G. McEachern, M.D. and (By Invitation) Robert E. Sullivan, M.D., Fort Wayne.

10:30 a.m. *Paralytic Ileus with Trauma:* Chester C. Guy, M.D., Chicago.

11:00 a.m. *Coffee Break.*

11:30 a.m. *Radical Retropubic Extracapsular Prostatectomy For Early Carcinoma of the Prostate:* Charles J. Cooney, M.D., and (By Invitation) Theo. V. Beutler, M.D., Fort Wayne.

11:45 a.m. *Some Difficulties in the Education of a Surgeon:* Isadore S. Ravdin, M.D., Philadelphia; Chairman, Board of Regents, A.C.S.

12:15 p.m. *Surgical Treatment of Spontaneous Pneumothorax:* John W. McCallister, M.D., Fort Wayne.

12:40 p.m. *Cardiovascular Surgery in an Outlying Community:* Robert P. Lloyd, M.D., and R. Morton Bolman, M.D., Fort Wayne.

12:45 p.m. *Pre-and Postoperative Fluid and Electrolyte Balance in Infants:* John R. Weber, M.D., Fort Wayne (By invitation).

1:00 p.m. Luncheon in Chatterbox and Oak Room.

2:15 p.m. *Carcinoid Tumors:* Louis A. Schneider, M.D. (By Invitation) Fort Wayne.

2:30 p.m. *Presidential Address:* James Leffel, M.D., Indianapolis.

2:45 p.m. *Plastic Grafts As Vascular Substitutes:* Harris B. Shumacker, M.D., Indianapolis.

3:10 p.m. *Radioactive Phosphorus in the Treatment of Brain Tumors:* Warren Hastings, M.D., and George Manning, M.D. (By Invitation), Fort Wayne.

3:25 p.m. *Surgery After Irradiation Failure:* Herbert E. Schmitz, M.D., Chicago.

3:50 p.m. *Caesarean Section:* Mahlon F. Miller, M.D., and (By Invitation) Donald S. Painter, M.D., Fort Wayne.

The following **Indiana members** of the American Laryngological, Rhinological and Otolaryngological Society attended the recent meeting of the Middle Section of the society at Cleveland: Drs. David E. Brown, Kenneth L. Craft, J. Kent Leasure, Raleigh E. Lingeman, Carl H. McCaskey, Ralph J. McQuiston, Marlow W. Manion, Russell A. Sage, J. William Wright and J. William Wright, Jr., all of Indianapolis; and Dr. Hugh A. Kuhn, Hammond.

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active against wide range of urinary pathogens, including staphylococci, gonococci, Escherichia coli

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DOSAGE: Adults—2 tablets or 2 tsp. q.i.d. first 2 days, thereafter, 1 tablet or 1 tsp. q.i.d. Children—1 cc. (16 drops) syrup per 10 lb. body weight first 2 days, thereafter, 0.5 cc. (8 drops) per 10 lb. SUPPLIED: Tablets, bottles of 50 and 500. Syrup, 1-pt. and 1-gal. bottles.

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1. Hughes, J., et al.: South. M. J. 47:1082, 1954.
2. Kerley, L., and Headlee, C. P.: J. Am. Pharm. A. (Scient. Ed.) 45:82, 1956

All Members of the
Indiana State Medical Association
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ANNUAL SCIENTIFIC SESSION OF THE

INDIANA CHAPTER
AMERICAN COLLEGE OF SURGEONS

WEDNESDAY, APRIL 24, 1957
8:30 a.m. TO 4:30 p.m.

Speakers will include Drs. I. F. Ravdin, George Crile, Bronson Ray, Herbert Schmitz, Harris Shumacker and many others.

VAN ORMAN HOTEL — FORT WAYNE

If you plan to attend, please notify:
R. Morton Bolman, M.D.
717 Broadway
Fort Wayne, Indiana

At the meeting Dr. Manion was elected secretary of the Middle Section and Dr. Craft named delegate to represent the Middle Section at the annual business meeting at Toronto.

Dr. Jack I. Taube has opened offices for the practice of ophthalmology at 1007 Hume Mansur Building, Indianapolis. Doctor Taube has recently returned from a two year tour of duty with the USAF School of Aviation Medicine at Randolph Field, Texas. His tour included duty in both Germany and Japan. Doctor Taube is certified by the American Board of Ophthalmology. Prior to entering service Doctor Taube was in practice at 512 Hume Mansur Building. He is married and has three daughters.

Venereal Disease Conference Planned by U. of Tennessee

Physicians and public health officers of Indiana are invited to attend the tuition-free 26th Venereal Disease Postgraduate Conference sponsored by the University of Tennessee College of

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WITH THE Davis technique,† using VAGISEC® liquid and jelly, flare-ups of vaginal trichomoniasis rarely occur. VAGISEC liquid actually explodes trichomonads within 15 seconds after douche contact.[1] Better than 90 per cent apparent cures follow use of this new trichomonacide,[2] developed as "Carlendacide" by Dr. Carl Henry Davis, noted gynecologist and author, and C. G. Grand, research physiologist.[3]

No trichomonad escapes—The overwhelming action of VAGISEC liquid dooms the trichomonad. One chelating agent and two surface-acting agents combine in attack to weaken the cell membrane, to remove waxes and lipid materials from the membrane surface, and to denature the protein. With its cell wall destroyed, the parasite imbibes water, swells and explodes. All this occurs within 15 seconds. Only scattered fragments remain.

No other agent or combination of agents kills the trichomonad in this specific fashion or with the *speed* of VAGISEC liquid.[3] When the patient uses VAGISEC jelly as well—the recommended routine—these good effects continue indefinitely.[4]

Reaches hidden trichomonads—Unlike many agents, VAGISEC liquid thoroughly penetrates and dissolves the cellular debris and mucoid material lining the vaginal surface.[3] It reaches hidden trichomonads — often the cause of treatment failure — as well as parasites swimming freely in the canal.

The Davis technique—Office therapy with VAGISEC liquid is combined with home treatment. Both liquid and jelly are prescribed.

OFFICE TREATMENT—*Wipe vaginal walls dry with cotton balls, then wash thoroughly for about three minutes with a 1:100 dilution of* VAGISEC *liquid. Remove excess fluid with cotton balls. Dr. Davis recommends three treatments the first week, two the second and one the third.*

HOME TREATMENT—*Patient douches with* VAGISEC *liquid every night or morning and then inserts* VAGISEC *jelly. Home treatment is continued through two menstrual periods, but omitted on office treatment days. Douching is contraindicated in pregnancy.*

Husband re-infects wife—Since "trichomonads may be passed from the infected male to the uninfected partner during coitus,"[5] prevent re-infection by recommending the use of prophylactics. Specify RAMSES,® the finest possible rubber prophylactic, transparent, very thin yet strong; or XXXX (FOUREX)® skins, of natural animal membrane — pre-moistened. Your prescription of one of these brands insures the protection afforded by Schmid quality prophylactics and assures full acceptance of your regimen. At all pharmacies.

Active ingredients in VAGISEC liquid: Polyoxyethylene nonyl phenol, Sodium ethylene diamine tetra-acetate, Sodium dioctyl sulfosuccinate. In addition, VAGISEC jelly contains Boric acid, Alcohol 5% by weight.

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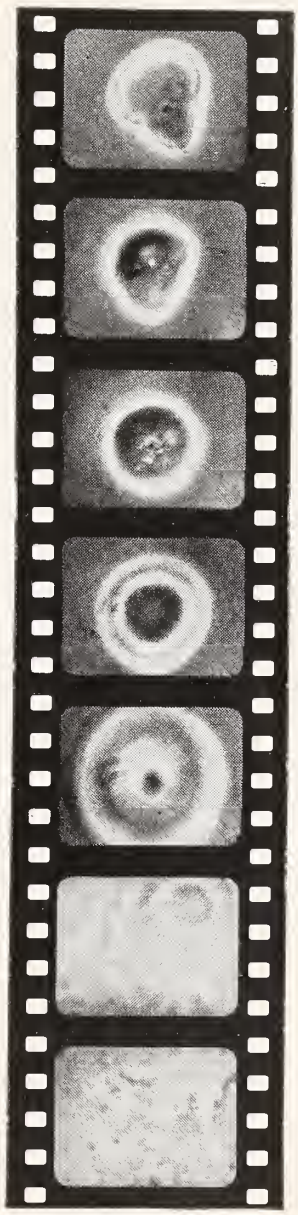

Top to bottom:
2 sec. CONTACTS
4 sec. COMPLEXES
6 sec. DISSOLVES
8 sec. DENATURES
10 sec. SWELLS
15 sec. EXPLODES
16 sec. SCATTERS

References: 1. Davis, C. H.: J.A.M.A. 157:126 (Jan. 8) 1955. 2. Davis, C. H.: West. J. Surg. 63:53 (Feb.) 1955. 3. Davis, C. H., and Grand, C. G.: Am. J. Obst. & Gynec. 68:559 (Aug.) 1954. 4. Davis, C. H. (Ed.): Gynecology and Obstetrics (revision), Hagerstown, Md., W. F. Prior, 1955, vol. 3, chap. 7, pp. 23-33. 5. Draper, J. W.: Internat. Rec. Med. 168:563 (Sept.) 1955.

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Medicine. The conference will be held at the college in Memphis on April 18, 19 and 20.

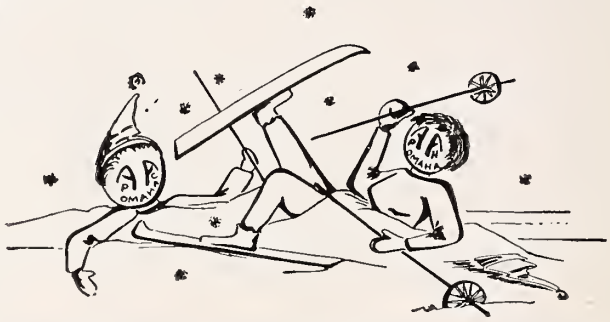
The course is designed to acquaint practitioners and health officers with the latest developments in the diagnosis, treatment, and management of the venereal diseases. Members of the American Academy of General Practice will be granted 20 units of Category I credit for full attendance during the conference.

The staff will be drawn from university faculties, U.S. Public Health Service, and other outstanding authorities in the field.

Applications for admission should be sent to Dr. Henry Packer, Department of Preventive Medicine, College of Medicine, University of Tennessee, Memphis 3, Tennessee.

Three new projects were approved for Indiana under provisions of the Hill-Burton Act during January. The Putnam County Hospital at Greencastle will receive $50,000 in federal funds; Marion General Hospital, $108,061; and Jackson County Schneck Memorial Hospital at Seymour, $85,000.

The Marion hospital is providing 66 additional



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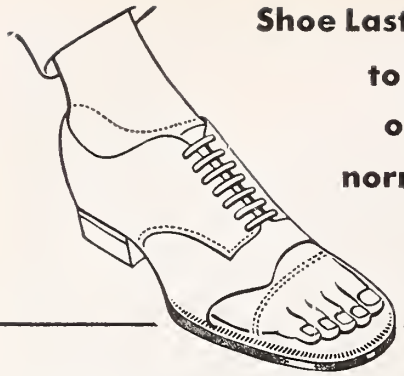

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beds at a total cost of $1,481,836. Sixty-five new beds are planned at Schneck hospital where total cost of improvements will be $842,175. Putnam County Hospital's remodeling and expansion program will cost a total of $716,956.

10th Symposium on Cancer Is Scheduled for I.U. March 26-27

"Mouth Cancer" will be the general topic of the 10th Annual symposium on cancer which will be presented to doctors and dentists at the Indiana University Medical Center on March 26 and 27.

Sponsored by the I.U. Schools of Medicine and Dentistry, with the support of the Indiana Division of the American Cancer Society, the program will be devoted exclusively to cancer of the oral cavity.

Dr. Don D. Bowers, Indianapolis, is chairman of the Indiana Cancer Division's professional education committee which arranged the program.

Guest panelists will include Dr. Reed O. Dingman, associate professor of oral surgery and assistant professor of surgery, University of

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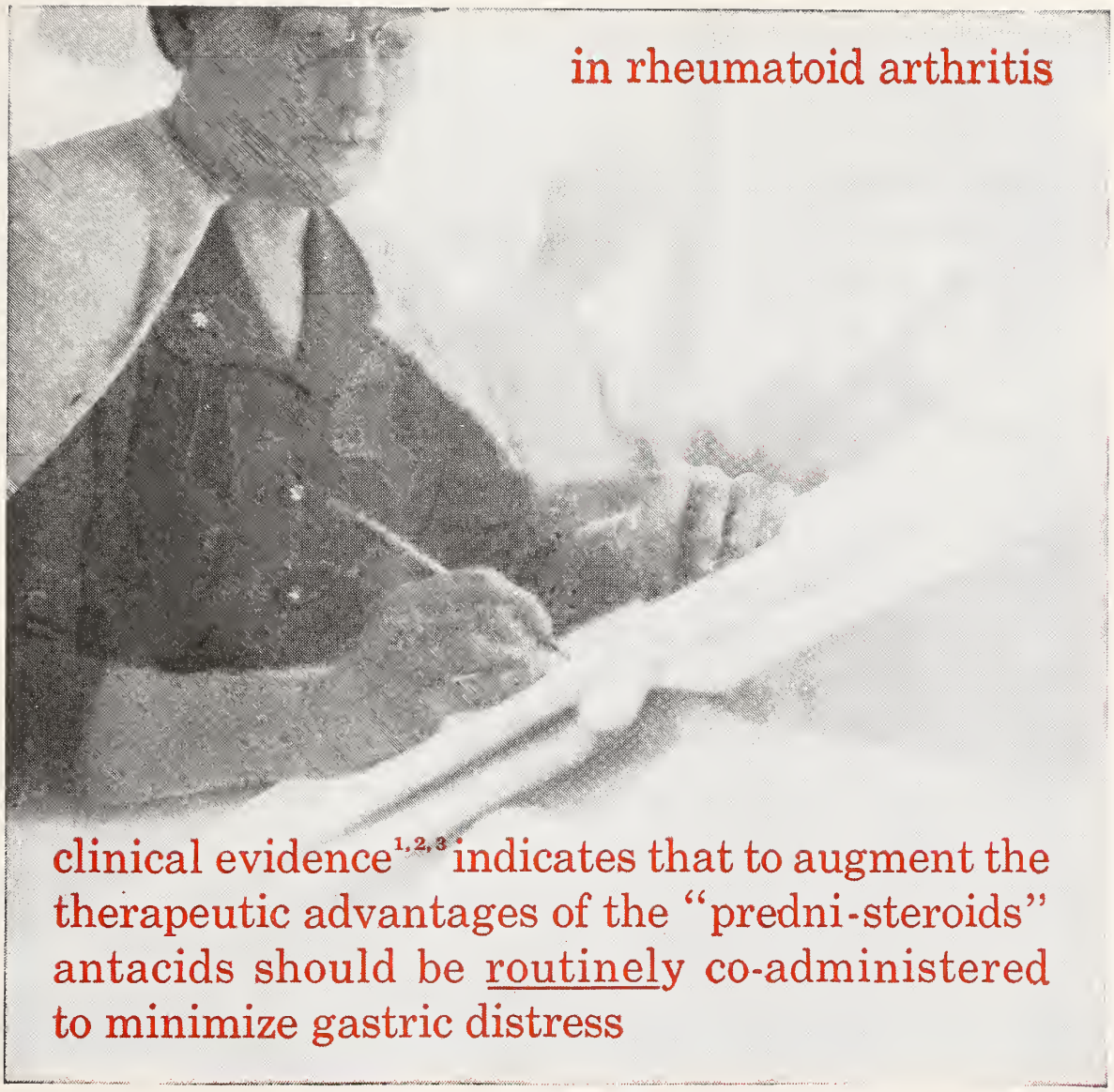

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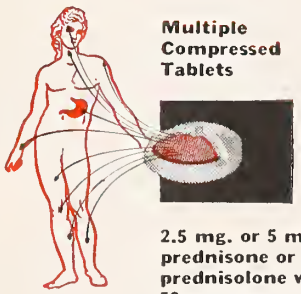

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References: 1. Boland, E. W., *J.A.M.A.* **160**:613 (February 25) 1956. 2. Margolis, H. M. *et al.*, *J.A.M.A.* **158**:454 (June 11) 1955. 3. Bollet, A. J. *et al.*, *J.A.M.A.* **158**:459 (June 11) 1955.

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Michigan; Dr. Milton T. Edgerton, associate professor of surgery (plastic), Johns Hopkins University; Dr. Gilbert H. Fletcher, professor of radiology, University of Texas; Dr. Richard E. Johnson, associate professor of pathology, University of Kansas; Dr. Isadore Lampe, professor of radiology, University of Michigan; Dr. Charles L. Martin, clinical professor of radiology, Southwestern Medical School, University of Texas; and Dr. Danely P. Slaughter, associate professor of surgery, University of Illinois.

Faculty participants will include Dr. Robert J. Rohn, associate professor of medicine; Dr. David Gastineau, assistant professor of radiology; Dr. Harold King, instructor in surgery; William G. Shafer, D.D.S., associate professor of histopathology; Dr. Harold M. Trusler, professor of surgery (plastic); Dr. Frank Vellios, associate professor of clinical pathology; and Dr. J. A. Campbell, professor and chairman, Department of Radiology.

Needs of the Expectant Family Subject of St. Mary's Institute

A two day institute on "Needs of the Expectant Family" will be held at Saint Mary's Hospi-

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Sgt. Elmer Paul, right, Indiana State Police, receives a certificate of honorable mention for his exhibit on Auto Crash Injury Research from Dr. Elton R. Clarke, president of the Indiana State Medical Association. The award was made by the American Medical Association in recognition of the Indiana exhibit shown at the AMA annual convention.

tal, Evansville, on April 11 and 12, sponsored by the Maternal and Child Health Council of the Indiana League for Nursing, and Saint Mary's Hospital. Among the outstanding speakers is Miss Aileen Hogan, R.N., Consultant on Maternity Nursing and Chairman of the National League for Nursing, Maternal and Child Health Council, Maternity Center Association, New York City. Her subject: "What and How Shall We Teach Expectant Parents?".

John E. Kooiker, M.D., assistant professor of psychology and director of the Adult Psychology Clinic at Indiana University School of Medicine will speak on "Psychological Aspects of Pregnancy and Labor". Panels and round table discussions are scheduled for the meeting which is open to physicians, registered nurses, and their special guests. A hospitality room will be sponsored by Mead Johnson. Tours of Saint Mary's new maternity section and of the Mead Johnson plant are included in the plans. Registration forms may be obtained by writing Mary Ruth Keller, R.N., Registration Chairman, Saint Mary's Hospital, 3700 Washington Avenue, Evansville, Indiana.

Graduate Course in Allergy Offered by ACA in Chicago

The American College of Allergists will conduct a graduate instruction course at the Pal-

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mer House in Chicago, March 17 to 19. Nonmembers will be charged fees of $50 for the full three-day course, $35 for two days and $20 for one day. Dr. Hugh A. Kuhn of Hammond will be chairman of the session on Allergy of the Nose, and Dr. Kenneth L. Craft of Indianapolis will be one of the instructors in this session. Dr. Kuhn is chairman of the Ophtho-Otolaryngologic Section of the Annual Congress which will meet from March 20 to 22. Dr. Bennett Kraft of Indianapolis is chairman of the Psychosomatic Section.

Sectional Meeting of College of Surgeons Scheduled for St. Paul

Members of the Indiana State Medical Association are invited to attend a three-day sectional meeting of the American College of Surgeons in St. Paul, April 8 to 10. The program includes papers and panel discussions on all aspects of general surgery. Gastro-intestinal surgery, treatment of traumatic injuries, biliary tract surgery, hemorrhagic diseases, treatment of breast malignancy, and discussions of gynecologic

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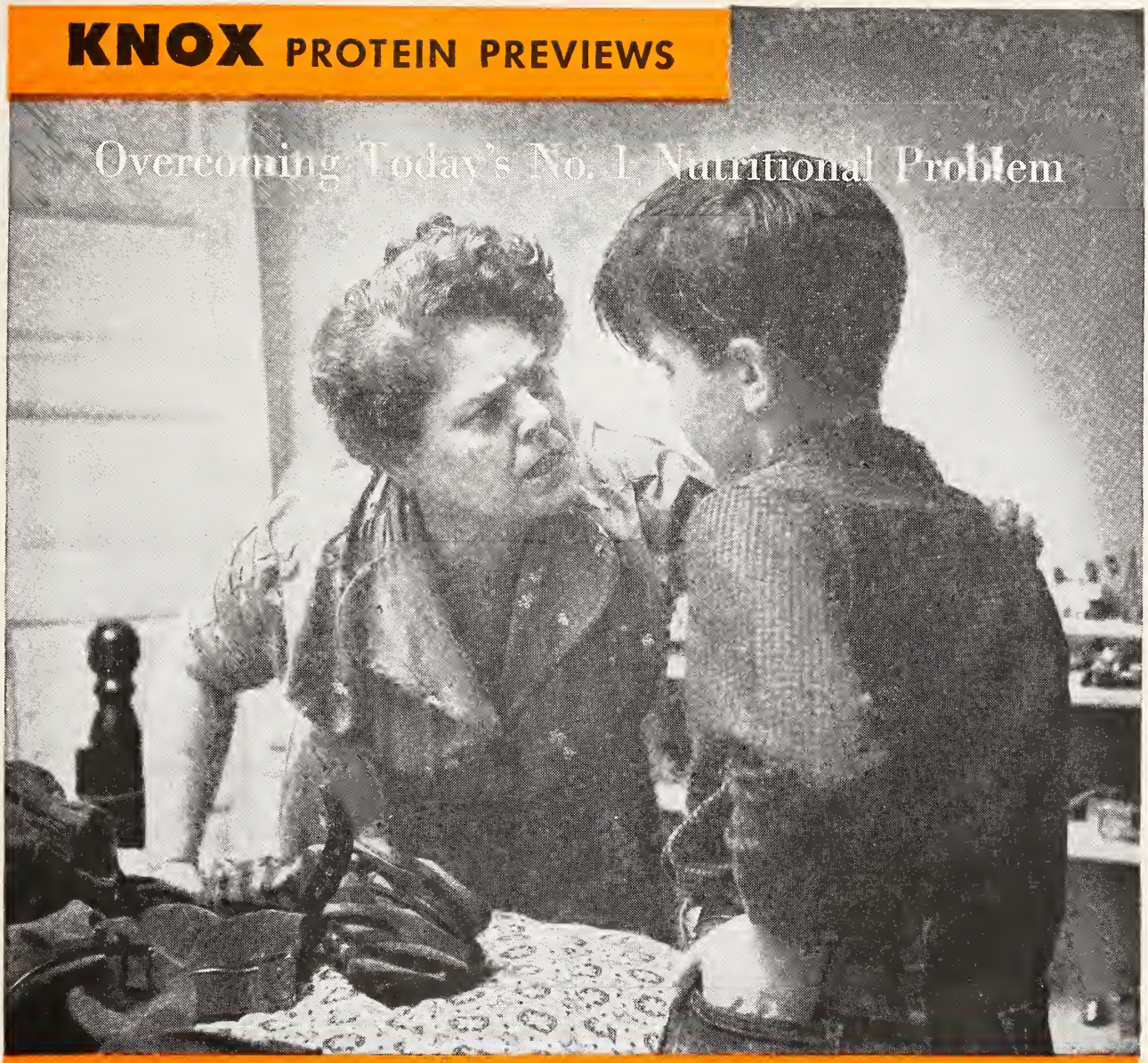

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1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

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problems will be included. A special ophthalmology session will be held on Tuesday, April 9.

Medical Program Combined with South Dakota Pheasant Hunting

The Hunter's Fall Medical Meeting sponsored by the South Dakota State Medical Association will be held at Mitchell, South Dakota during the first five days of pheasant hunting season in October, 1957.

The program is set up for out-of-state doctors and will feature morning scientific sessions, afternoon hunting and evening scientific and social sessions.

The registration fee is set at $100.00 which will cover the out-of-state hunters license, hunting guides, reserved hunting areas, several social events, and the scientific program. Motel and hotel space has been reserved, but registration is limited to the available housing.

The affair is not stag, but wives who hunt must pay the full registration fee and those not hunting, three-fourths of it. (This is necessitated by the tight housing situation.)

For details and reservations write to John C. Foster, Executive Secretary, South Dakota Med-

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patient: 60-year-old female. After death of relative from cancer, patient developed severe epigastric pain, was convinced pain was due to hidden malignancy which defied the X-ray. Her pain was unresponsive to antispasmodics. Her severe cancerphobia was untouched by sedatives and she refused psychotherapy.

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This case report is from the files of the patient's physician; photo professionally posed.

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Northern Tri-State Medical Association to Meet April 11

The 84th annual meeting of the Northern Tri-State Medical Association will be held in the Academy of Medicine Building, 3101 Collingwood Blvd., Toledo, on April 11.

First scientific speaker will be Dr. W. R. Kirtley, associate in medicine, I.U. School of Medicine and director of medical research at Eli Lilly and Company. His subject will be "Oral Hypoglycemic Agents".

Registration opens at 8 a.m. (EST), and the last speaker, Dr. George Crile, Jr., is scheduled for 4 p.m.

Officers of the Association include Dr. R. A. Fargher, LaPorte, first vice-president, and Dr. Donald G. Mason, Angola, secretary-treasurer. Indiana members of the council are Drs. Loren Jinnings, Garrett, and Milton Popp, Fort Wayne.

Registration with check for $5.00 and $3.00 for luncheon should be mailed to Dr. Donald G. Mason, Angola, Indiana.

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RESULTS OF PHYSICALS

During the annual A.M.A. meeting in Chicago there was an exhibit booth, equipped with x-ray and electrocardiograph, where physicians could be examined. The booth, entitled "A Yearly Physical Examination for Every M.D.," was a joint enterprise of the A.M.A. Section on General Practice, the American Academy of General Practice, and the National Tuberculosis Association.

Within a few moments the ECG tracing and the x-ray diagnosis were made available to the physician. Dr. I. E. Buff, Charleston, W. Va., cardiologist who was on duty at the booth and read many of the tracings, is convinced after his experience that many doctors are too neglectful of their health.

A study of the results revealed one surprising fact: 58 doctors or 6 per cent of the total who underwent x-ray examination had suspected tuberculosis.

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

January 19, 1957

Roll call showed the following present: James W. Denny, M.D., chairman; E. H. Clauser, M.D.; Elton R. Clarke, M.D.; M. C. Topping, M.D.; Wemple Dodds, M.D.

Albert Stump and Robert Hollowell, attorneys; R. J. Amick and K. W. Bush, field secretaries; James A. Waggener, executive secretary.

Membership Report

Number of members January 18, 1957 . . . . 1,696*
Number of members January 18, 1956 1,196
Gain over last year 500
Number of members December 31, 1956 . . . 4,048
*Includes 57 in military service (gratis)
40—$10 members (residents and interns)
168—senior members
43—members, dues remitted by Council

Number who have paid AMA dues:
January 18, 1957 . . . . . 1,308**
** Includes 497 exempt members (gratis)—
410 prior to January 1, 1957;
87 so far this year

Headquarters Office

Mr. Amick and Mr. Bush gave a year-end report covering their activities during 1956.

The secretary reported on the operation of the Medicare program to date, stating that 67 claims had been received from Indiana physicians.

The secretary reported on his meeting with the officials of the Department of Social Security in Baltimore on December 17 and a meeting with the McVay Committee of the Council on Medical Service of the AMA, and the OASI Medical Advisory Committee and officials of the Department of Social Security in Washington on January 11. He reported that the Medical Advisory Committee of the OASI was violently opposed to the Indiana recommendation that rotating committees be established at the county or regional level for the purpose of carrying out the administration of Public Law 880. It was his understanding that the Board of Trustees of the AMA would receive a recommendation from the McVay Committee that medical advisory committees be established at the state level.

Statements of Receipts and Expenditures for December for the Association and THE JOURNAL were approved.

Treasurer's Office

In the absence of the treasurer the treasurer's report, compiled by the auditors, George S. Olive and Company, was given by Dr. Topping. Upon motion by Drs. Topping and Dodds the auditors' report was accepted.

Organization Matters

Medicare. The secretary reported receipt of a letter from Blue Shield Board, a letter from Mr. Hollowell to the Department of Defense regarding interpretation of the contract, as well as a letter from Mr. Stump on behalf of the Blue Shield Board to the Department of Defense and the answer to Mr. Stump's letter. The replies from the Department of Defense substantiated the position previously taken by the Association that Blue Shield's only responsibility as fiscal administrator in the Indiana Medicare program was to pay claims as approved by the Association and to carry out the other duties as outlined in the contract.

Medicare Contract Modification No. 5, dated January 15, 1957, in which the Department of Defense notified the Association that the fund obligated by the Indiana contract was raised to the sum of $170,000.00, was accepted by consent.

The secretary also read a letter dated January 9, in reply to his request to the Department of Defense, for information concerning the giving of polio shots and other drugs in obstetrical care. The letter authorized payment of polio shots and medicines given in obstetrical cases providing the physician indicates such is a necessary part of the complete care and treatment of the patient.

The secretary presented to the committee the news letter of the Ohio State Medical Association, dated January 15, 1957, in which it was announced that through failure of the Ohio State Medical Association to enter into a contract with the Department of Defense, said Department had contracted with Mutual of Omaha to establish and administer the physicians' program in the State of Ohio.

White County hospital situation. Correspondence regarding the White County hospital situation was reviewed by the committee and following discussion the secretary was instructed to notify the society that the Association would lend its assistance to this problem. This was approved by consent.

Letter from the Indiana Association of Pathologists in which they recommended that a pathologist should be a member of the State Board of Health and in which they submitted names of three of their members for consideration was discussed and upon motion of Drs. Clarke and Dodds the secretary was to discuss this with Dr. Offutt and if he advised this information was to be transmitted to the Governor of Indiana.

Letter from Dr. W. B. Matthew, chairman of the Committee on Conservation of Vision, in which he pointed out that his committee recommended

HOME LAWN, being a health resort, is equipped with all possible facilities to aid in restoring a better state of health to those who need our best assistance—plus the joy and restfulness of being bathed by private attendants in mineral water at just the right temperature.

Many come just to bathe in the mineral waters, getting away from business or social activities while others prefer going under the care of a physician for special hydrotherapy treatments.

HOME LAWN maintains a special diet kitchen, dietician, and physician in charge. Indoor recreational activities.

HOME LAWN MINERAL SPRINGS

MARTINSVILLE, INDIANA

Medical Staff:

M. C. Pitkin, M.D., *Director*
J. W. Gibbs, M.D.
R. D. Miller, M.D.

Information upon request

MARTINSVILLE MINERAL SPRINGS UNDER THE SAME OWNERSHIP — LOWER RATES

that no change be made in the State law concerning the use of the Crede method in the treatment of the eyes of the newborn was discussed and approved upon motion of Drs. Clauser and Clarke.

On motion of Drs. Dodds and Clarke the Association agreed to take a page ad in the forthcoming convention issue of the Hoosier State Press Association bulletin.

The secretary read a letter from the American Medical Association urging representation of the Indiana State Medical Association at a meeting in Chicago on January 26 to discuss the polio situation. On motion of Drs. Clauser and Clarke, Dr. Minor Miller, chairman of the Polio Committee, and Dr. Earl Mericle, chairman of the Public Relations Committee, are requested to attend this meeting.

The secretary reported on the post card survey of members of the Council regarding the suggestion that money be sent for the assistance of Hungarian refugee physicians, in which four members of the Council voted on sending $1,000.00, eight on $500.00, and one voted "No." Upon motion of Drs. Clarke and Topping, the committee voted to send $500.00.

The secretary read a report on AMEF showing that the fifth year of operation of the plan had produced a record total of $1,072,717.00, representing a 41 per cent increase over the 1955 national total.

Letter from Dr. Harlan English, Regional Legislative Contact for the American Medical Association, was read, in which he urged the appointment of legislative key men. Inasmuch as this matter was to be discussed at the Council meeting, no action was taken.

A notice from the Lambert Mailing Company stating that they found it necessary to increase the price for addressing News Flash envelopes from $4.70 to $5.02 per thousand was approved on motion of Drs. Dodds and Topping.

The secretary reported information had been received by him that a firm by the name of Alan S. Feldman of New York City had contacted Indiana hospitals, making inquiry whether or not they would be willing to sell their property to an investment group which he represented. He further reported that upon inquiry neither the American Medical Association nor the American Hospital Association had any knowledge in this matter.

The secretary inquired on behalf of the Committee on Legislation as to what was the desire of the Association regarding the proposal of legislation concerning the control of insecticides. Upon motion of Drs. Clarke and Dodds, the Association is to start proceedings immediately to get a bill prepared and passed by the State Legislature on this subject.

On motion of Drs. Topping and Dodds the Executive Committee approved the Constitution and bylaws of the Indiana Association of Medical Assistants.

The Journal

Letters read from C. E. Pauley and Company, printers of THE JOURNAL, notifying the Association that effective February 1 there would be a further increase in the price of printing. Upon motion of Drs. Clarke and Dodds the notice was accepted.

Report on advertising in THE JOURNAL for the month of January was not available.

Future Meetings

State Veterans' Affairs Committees, Chicago, January 26, 1957. By consent it was agreed that Dr. Clarke, Dr. James W. Crain, and Dr. Lester D. Bibler should attend this meeting.

Regional Medical-Legal Symposiums. It was agreed that no one from Indiana would represent the Association at any of the forthcoming Medical-Legal conferences which will be held in Atlanta, Denver and Philadelphia in March.

State AMEF Chairmen, Chicago, January 27, 1957.

Congress on Medical Education and Licensure, Chicago, February 10 and 11, 1957. On motion of Drs. Dodds and Clauser, approval was given for Dr. Harry E. Klepinger, chairman, and Drs. Maurice E. Glock and James H. Gosman, members of the Committee on Medical Education and Licensure, to attend these meetings.

Association of American Medical Colleges, Chicago, February 9, 1957.

Blue Shield Professional Relations Conference, Chicago, February 11, 12, and 13, 1957. On motion of Drs. Clauser and Dodds, the secretary was instructed to accept the invitations to attend these meetings.

Polio meeting, Chicago, January 26, 1957. By consent, Dr. Minor Miller, chairman of the Committee on Polio, Dr. Earl Mericle, chairman, Committee on Public Relations, and the secretary, were authorized to attend this meeting.

There being no further business the Committee adjourned to meet again at 3:00 p.m. on Wednesday, March 6, 1957, at the Student Union Building, Indianapolis.

MINUTES OF MEETING OF THE EXECUTIVE COMMITTEE WITH THE WOMAN'S AUXILIARY TO THE INDIANA STATE MEDICAL ASSOCIATION, I. U. STUDENT UNION BUILDING, INDIANAPOLIS

January 19, 1957

Present: Mrs. William R. Tindall, President
Mrs. William E. Sutton, Corresponding Secretary
Mrs. John M. Sullivan, Treasurer
Mrs. Elton R. Clarke

Executive Committee members: James W. Denny, M.D., chairman; E. H. Clauser, M.D.; Elton R.

Clarke, M.D.; M. C. Topping, M.D.; Wemple Dodds, M.D.

Mrs. Tindall reviewed the activities of the Auxiliary and presented newspaper clippings and copies of publicity received by some of the county auxiliaries in carrying out the activities requested by the Rural Health Committee. She also presented the Auxiliary program book for review of the committee.

Mrs. Tindall stated that the Indiana Auxiliary had financial problems due largely to the expanded program which had been brought about by the requests of the Association. She presented evidence showing that surrounding state medical associations financially assist their Auxiliary programs. After a lengthy discussion, on motion of Drs. Dodds and Topping it was voted to give the Auxiliary $1,000.00 for its use during the year 1957. The Auxiliary is to report its use at the end of the year to the committee.

The Auxiliary also raised the question of storage for the historical records of the Auxiliary which are presently being stored in the garage at the home of Mrs. Lybrook in Young America. It was suggested that the secretary might be able to store this in the headquarters office, providing it didn't take more space than one additional filing cabinet.

There being no further business the meeting was adjourned.

INDIANA STATE MEDICAL ASSOCIATION

The Council

January 20, 1957

The Council of the Indiana State Medical Association convened for its midwinter meeting at 10:00 a.m., Sunday, January 20, 1957, in Room M-124, Indiana University Student Union Building, Indianapolis, with Dr. Wemple Dodds, chairman, presiding.

Roll call showed the following present:

Councilors:

First District—Not represented
Second District—J. H. Crowder, Sullivan
Third District—John M. Paris, New Albany, alternate councilor, and AMA alternate delegate.
Fourth District—J. E. Dudding, Hope
Fifth District—M. C. Topping, Terre Haute
Sixth District—Harry P. Ross, Richmond
Seventh District—Ralph V. Everly, Indianapolis
Eighth District—Guy A. Owsley, Hartford City; Gordon B. Wilder, Anderson, alternate councilor, and AMA delegate
Ninth District—Wemple Dodds, Crawfordsville; Kenneth O. Neumann, Lafayette, alternate
Tenth District—James P. Vye, Gary
Eleventh District—Max R. Adams, Flora
Twelfth District—Maurice E. Glock, Fort Wayne
Thirteenth District—G. O. Larson, LaPorte

Officers:

Elton R. Clarke, Kokomo, president
M. C. Topping, Terre Haute, president-elect

Journal:

Frank B. Ramsey, Indianapolis, editor

Executive Committee:

James W. Denny, Indianapolis, chairman
E. H. Clauser, Muncie
Albert Stump, attorney
Robert Hollowell, attorney
Robert J. Amick, field secretary
Kenneth W. Bush, field secretary
J. A. Waggener, executive secretary

Guests:

Cleon A. Nafe, Indianapolis, AMA delegate
Wendell C. Stover, Boonville, AMA delegate
E. S. Jones, Hammond, AMA delegate
Earl W. Mericle, Indianapois, alternate delegate and chairman, Committee on Public Relations
Andrew C. Offutt, Indianapolis, State Health Commissioner
Don E. Wood, Indianapolis, co-chairman, Committee on Public Policy and Legislation

On motion of Drs. Crowder and Dudding, the minutes of the meetings of the Council held at Indianapolis on October 15 and 18, 1956, were approved as printed in the December, 1956, issue of THE JOURNAL.

COUNCIL REFERENCE COMMITTEES

The chairman announced that inasmuch as he was asking to be relieved of the chairmanship of the Council he would leave the appointment of 1957 Council reference committees to the new chairman.

REPORTS OF COUNCILORS

The councilors reported 1957 district meetings scheduled as follows:

First district—_____, 1957
Second District—Linton, June 6, 1957
Third District—Bedford, May 15, 1957
Fourth District—Greensburg, May 1, 1957
Fifth District—_____, 1957
Sixth District—Liberty, May 9, 1957
Seventh District—_____, 1957
Eighth District—Muncie, June 12, 1957
Ninth District—Fowler, May 23, 1957
Tenth District—_____, May __, 1957
Eleventh District—_____, 1957
Twelfth District—Pokagon State Park, May 15, 1957
Thirteenth District—South Bend, November 20, 1957

Dr. Larson reported that Dr. Benedict A. Biasini, South Bend, had been elected alternate councilor for the Thirteenth District.

REPORTS OF OFFICERS

Dr. Elton R. Clarke, president: "I want to thank the various committee members for the way they are getting into action on these committees this year. I think those two big committee meetings we had at the outset helped to get things going; and since then a good many of the important committees have had secondary meetings of organization and are getting well started on the program.

"I want to commend the Rural Health Committee for a very successful meeting which they held here on January 6th and the work done by Dr. Dudding and Dr. Davis and the State Committee with that of the National Rural Health Conference. That is

going along in a very fine way with the aid of the Auxiliary.

"The Committee on Preceptorship Sub-Committee and the Medical Education and Registration Committees have held meetings that have been well attended and several good things have come out of those meetings.

"We are anxious within the next month now, to hold another one of these joint committee meetings, getting together all of the public health agency committees. That is under the chairmanship of Dr. Montgomery and Dr. Hayes of Muncie. We hope to have another one of those sessions where we can call together all those committees and try to plan some organized work. Before too long, we will want to run things a little farther along toward the convention. We want to have a combined session of all the convention committees and see how far along we are with that. I might say that progress has been very satisfactory on that, on those convention committees, and I think we are going to have a good show for you in October."

Treasurer's report. In the absence of Dr. O. W. Sicks, treasurer, each councilor was given a copy of the report on the financial condition of the Association for the year ending December 31, 1956, compiled by George S. Olive and Company, certified public accountants. On motion of Drs. Clarke and Ross, this report, which follows, was approved:

January 12, 1957

The Council,
Indiana State Medical Association,
Indianapolis, Indiana.

Gentlemen:

We have examined the statement of financial condition of the Indiana State Medical Association as of December 31, 1956, and the statements of income and expense and fund balances for the year then ended, on a cash receipts and disbursements basis. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying financial statements, on a cash receipts and disbursements basis, present fairly the position of the Indiana State Medical Association at December 31, 1956, and the results of its operations for the year then ended, in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Yours very truly,

GEO. S. OLIVE & CO.,
Certified Public Accountants.

Exhibit A

INDIANA STATE MEDICAL ASSOCIATION

Statement of Assets, All Funds, at December 31, 1956

GENERAL FUND:				
Petty cash fund			$ 1,500.00	
Loan to North Central District Blood Bank Clearing House			1,000.00	
Investments:				
U. S. Treasury bills		$ 10,000.00		
U. S. Treasury bonds		115,000.00		
U. S. Savings bonds		96,000.00		
			221,000.00	
			223,500.00	
Deduct: Bank overdraft—exhibit C			686.99	
			222,813.01	
Add: Due from Medical Defense fund			75.00	
Total general fund				$222,888.01
THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION:				
Cash on deposit—exhibit D				8,572.80
MEDICAL DEFENSE FUND				
Cash on deposit—exhibit E			4,405.98	
Investments:				
U. S. Treasury bills		3,000.00		
U. S. Treasury bonds		14,000.00		
U. S. Savings bonds		9,000.00		
			26,000.00	
			30,405.98	
Deduct: Due to general fund			75.00	
Total Medical Defense fund				30,330.98
STUDENT LOAN FUND:				
Cash on deposit-exhibit F			3,688.38	
Notes receivable from medical students			1,500.00	
Investments:				
U. S. Treasury bills			5,000.00	
Total Student Loan Fund				10,188.38
TOTAL ASSETS, ALL FUNDS—exhibit B				**$271,980.17**

Exhibit B

INDIANA STATE MEDICAL ASSOCIATION
Analysis of Increase in Assets, All Funds,

Year Ended December 31, 1956

TOTAL ASSETS, DECEMBER 31, 1956—exhibit A	**$271,980.17**
TOTAL ASSETS, JANUARY 1, 1956	**258,426.29**
NET INCREASE	**$ 13,553.88**

Arising from the following sources:			
Excess of operating cash receipts over operating cash disbursements, year ended December 31, 1956:			
General fund—exhibit C:			
Receipts	$134,448.79		
Disbursements	124,658.42		
		$ 9,790.37	
The Journal of the Indiana State Medical Association—exhibit D:			
Receipts	58,210.50		
Disbursements	56,570.32		
		1,640.18	
Medical Defense Fund—exhibit E:			
Receipts	5,357.15		
Disbursements	3,422.20		
		1,934.95	
Student Loan Fund—exhibit F:			
Receipts	298.63		
Disbursements	110.25		
		188.38	
NET INCREASE			**$ 13,553.88**

Exhibit C

INDIANA STATE MEDICAL ASSOCIATION

Comparative Statement of Cash Receipts and Disbursements, Years Ended December 31, 1956, and December 31, 1955

GENERAL FUND

	Year Ended Dec. 31, 1956	Year Ended Dec. 31, 1955	Increase (Decrease)
CASH BALANCE AT BEGINNING OF YEAR	$ 13,497.53	$ 37,410.74	$(23,913.21)
RECEIPTS:			
Membership dues	105,464.00	103,340.00	2,124.00
Income from exhibits	21,205.00	13,150.00	8,055.00
Interest income and discount on securities purchased	6,515.59	4,718.00	1,797.59
Deduct: Interest income held by Medical Defense fund—exhibit E.	(100.00)	------	(100.00)
Instructional courses	623.50	485.50	138.00
Collections on notes and scholarship agreements	700.00	------	700.00
Payment stopped on prior years' outstanding checks	40.70	------	40.70
Sale of book "One Hundred Years of Indiana Medicine"	--------	2.50	(2.50)
Total—exhibit A	134,448.79	121,696.00	12,752.79
Redemption of securities	82,000.00	5,000.00	77,000.00
Total receipts	216,448.79	126,696.00	89,752.79
BEGINNING BALANCE PLUS CASH RECEIPTS	229,946.32	164,106.74	65,839.58
DISBURSEMENTS:			
Transfer of applicable portion of dues to: The Journal of The Indiana State Medical Association—exhibit D	11,547.00	11,382.00	165.00
Medical Defense fund—exhibit E	4,615.00	4,552.50	62.50
Premium on purchase of securities	--------	21.52	(21.52)
Headquarter's office expense	60,111.76	51,785.19	8,326.57
Council	1,054.77	983.40	71.37
Officers	8,129.76	4,191.99	3,937.77
Annual session	18,844.98	11,285.19	7,559.79
Standing committees—schedule C-1	11,453.26	14,381.66	(2,928.40)
Special committees	2,219.11	1,147.05	1,072.06
Federal insurance contributions tax	487.20	482.40	4.80
Indiana and federal unemployment compensation tax	73.44	72.01	1.43
Fifty-year club	249.91	321.60	(71.69)
Employees' retirement fund	5,872.23	------	5,872.23
General practitioner award	------	2.70	(2.70)
Total—exhibit A	124,658.42	100,609.21	24,049.21
Transfer to Student Loan fund	10,000.00	------	10,000.00
Purchase of securities—general fund	92,000.00	50,000.00	42,000.00
Purchase of securities for Medical Defense fund for which reimbursement has not yet been made	2,974.89	------	2,974.89
Loan to North Central District Blood Bank Clearing House	1,000.00	------	1,000.00
Total disbursements	230,633.31	150,609.21	80,024.10
CASH BALANCE (OVERDRAFT) AT END OF YEAR	$(686.99)	$13,497.53	$ 14,184.52

Exhibit D

(Exhibit A)

INDIANA STATE MEDICAL ASSOCIATION

Comparative Statement of Cash Receipts and Disbursements,

Years Ended December 31, 1956, and December 31, 1955

THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION

	Year Ended Dec. 31, 1956	Year Ended Dec. 31, 1955	Increase (Decrease)
CASH BALANCE AT BEGINNING OF YEAR	$ 6,932.62	$ 6,078.97	$ 853.65
RECEIPTS:			
Subscriptions—members—exhibit C	11,547.00	11,382.00	165.00
Subscriptions—non-members	266.00	571.00	(305.00)
Advertising	44,352.01	37,413.63	6,938.38
Collections on accounts receivable	------	161.20	(161.20)
Single copy sales	150.50	173.75	(23.25)
Sales of reprints	1,805.39	2,409.80	(604.41)
Sale of scrap metal	89.60	15.41	74.19
Total receipts—exhibit A	58,210.50	52,126.79	6,083.71
BEGINNING BALANCE PLUS CASH RECEIPTS	65,143.12	58,205.76	6,937.36
DISBURSEMENTS:			
Salaries	10,451.55	10,090.00	361.55
Printing and reprints	39,898.32	35,768.83	4,129.49
Office expense	775.80	736.97	38.83
Electrotypes	2,255.28	2,046.83	208.45
Press clippings	139.30	142.70	(3.40)
Rent and electricity	1,170.16	635.36	535.10
Bulk mailing and addressing	945.70	922.50	23.20
Telephone and telegraph	276.91	256.90	20.01
Federal insurance contributions	187.80	181.80	6.00
Indiana and federal unemployment compensation tax	31.57	31.56	.01
Blue Cross hospital insurance	88.80	82.80	6.00
Copyright fees	48.00	48.00	------
Miscellaneous supplies	2.10	18.30	(16.20)
Envelopes	147.30	132.30	15.00
Photographs	13.50	71.05	(57.55)
Miscellaneous	137.93	107.24	30.69
Total disbursements—exhibit B	56,570.32	51,273.14	5,297.18
CASH BALANCE AT END OF YEAR	$ 8,572.80	$ 6,932.62	$ 1,640.18

(Exhibit A)

Exhibit E

INDIANA STATE MEDICAL ASSOCIATION

Statement of Cash Receipts and Disbursements, Year Ended December 31, 1956

MEDICAL DEFENSE FUND

BALANCE JANUARY 1, 1956				$ 8,496.14
RECEIPTS:				
Transfer of applicable portion of dues from the general fund—exhibit C			$ 4,615.00	
Interest—applicable to Medical Defense fund	$ 642.15			
Add: Interest applicable to general fund—exhibit C	100.00			
			742.15	
Total—exhibit A			5,357.15	
Redemption of securities			8,000.00	
Total receipts				13,357.15
				21,853.29
DISBURSEMENTS:				
Malpractice fees			270.00	
Attorney fees			3,090.00	
Travel expenses			62.20	
Total—exhibit A			3,422.20	
Purchase of securities	17,000.00			
Deduct: Cost of securities purchased by general fund for which reimbursement has not yet been made	2,974.89			
			14,025.11	
Total disbursements				17,447.31
BALANCE DECEMBER 31, 1956—exhibit A				$ 4,405.98

Exhibit F

INDIANA STATE MEDICAL ASSOCIATION

Statement of Cash Receipts and Disbursements, Seven Months Ended December 31, 1956

STUDENT LOAN FUND

RECEIPTS:			
Interest			$ 98.60
Donations			200.03
Total—exhibit A			298.63
Transfer from general fund—exhibit C			10,000.00
Redemption of securities			10,000.00
Total receipts			20,298.63
DISBURSEMENTS:			
Stationery and printing—exhibit B		$ 110.25	
Loans to students		1,500.00	
Purchase of securities		15,000.00	
Total disbursements			16,610.25
BALANCE, DECEMBER 31, 1956—exhibit A			$ 3,688.38

outstanding appetite stimulant

INCREMIN*

LYSINE-VITAMIN SUPPLEMENT LEDERLE

Problem-eaters, the underweight, and generally below-par patients of all ages respond to INCREMIN.

INCREMIN offers l-Lysine for protein utilization, and essential vitamins noted for outstanding ability to stimulate appetite, overcome anorexia.

Specify INCREMIN in either Drops (cherry flavor) or Tablets (caramel flavor). Same formula. Tablets, highly palatable, may be orally dissolved, chewed, or swallowed. Drops, delicious, may be mixed with milk, milk formula, or other liquid; offered in 15 cc. polyethylene dropper bottle.

Each INCREMIN Tablet
or each cc. of INCREMIN Drops *contains:*

l-Lysine	300 mg.	Pyridoxine (B_6)	5 mg.
Vitamin B_{12}	25 mcgm.	(INCREMIN Drops contain 1% alcohol)	
Thiamine (B_1)	10 mg.		

Reg. U. S. Pat. Off.

Dosage only 1 INCREMIN TABLET or 10-20 INCREMIN Drops daily.

LEDERLE LABORATORIES DIVISION
AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK

Schedule C-1

INDIANA STATE MEDICAL ASSOCIATION

Analysis of Standing Committees Expenses, Year Ended December 31, 1956

COMMITTEE	
Medical Education and Licensure	$ 1,270.04
Publicity	687.25
Public Relations	5,582.04
Preceptorship	185.60
Rural Health	1,332.26
Conference of Medical Society Officers	277.75
Industrial Health	174.60
Public Policy and Legislation	1,625.27
Scientific Work	64.50
Grievance	68.70
Physician-Hospital Relations	16.50
Constitution and By-Laws	42.75
Miscellaneous	126.00
Total—exhibit C	$11,453.26

Dr. Wendell C. Stover, delegate to the A.M.A., outlined briefly the actions taken by the A.M.A. House of Delegates at the clinical meeting held in Seattle, November 27 to 30, 1956, followed by discussion by Drs. E. S. Jones and Cleon A. Nafe, A.M.A. delegates. (See January, 1957, JOURNAL, for full report).

UNFINISHED BUSINESS

1. *Medical Education Foundation Fund.* The secretary read the following report on the amounts received for this fund:

1952	$ 63,163.04
1953	42,425.16
1954	49,868.62
1955	24,963.91
1956	19,075.00
1957 through January 18	1,460.00
	$200,955.73

Discussion by Drs. Ross and Denny regarding the confusion that has arisen in Indiana due to the fact that the A.M.A. has sent out appeals for funds at the same time that Indiana has made an effort to handle its own solicitation, emphasized the fact that members should send their contributions directly to the state headquarters office, 1021 Hume Mansur Building, Indianapolis 4, Indiana.

2. *Student Loan Fund.* Dr. Ross, chairman, reported that his committee had already screened four applicants, had granted four loans and had several more applications in process. A lengthy discussion of the value and practicability of the Student Loan Fund by Drs. Ross, Denny, Larson, Glock and Crowder ensued.

3. *Medical Care for Military Dependents.* Mr. Waggener reported as follows: "As of the present time we have received a total of 67 claims from Indiana physicians for service; sixteen of which have been screened and approved and passed on to Blue Shield for payment; eight are now in the field in the hands of the committee for approval; twenty are being held awaiting a meeting of the committee for action, and twenty-three have been returned to the physician for one thing or another."

Mr. Waggener also reported that he had been invited to Baltimore on December 17 to present the Indiana plan to the Social Security officials, and on January 11, at the request of the A.M.A. he had met in Washington with the McVay committee of the Council on Medical Service, to whom the Board of Trustees had referred the Indiana resolution. While the Department was interested in the proposal, the Medical Advisory Committee, appointed by the Social Security Division and chairmanned by Dr. Duffy Hancock of Kentucky, did not feel that such a plan was necessary in the operation of the program. It is understood that the final result will be that the McVay Committee will recommend to the Board of Trustees that they in turn will recommend to the House of Delegates at the June, 1957 meeting that Medical Advisory Committees be appointed by the various state medical associations. "I think the idea as presented in the Indiana resolution is lost at the present time," the secretary reported.

4. *Public Relations.* Dr. Earl Mericle, chairman of the Committee on Public Relations, reported that his committee is planning three projects for 1957:

(1) A meeting to bring representatives in from each of the county medical societies for a program planned toward development of public relations in the county societies, with speakers largely from the Public Relations Committee;

(2) A meeting to bring into Indianapolis all of the coaches, trainers and personnel connected with athletics in Indiana high schools, for presentation of a program of preventive medicine as regards injuries, heart and other conditions of students who participate in athletics. "We plan to have an orthopedic surgeon, neurologist and heart and chest man, and a person who is trained in physical education medicine to talk to these people with regard to prevention of these injuries and treatment of them once they occur." This will be a luncheon meeting with an outstanding speaker.

(3) Continuation of support of the Science Fair, which will be held in California this year.

Dr. Mericle asked for $500.00 to defray expenses of the meeting for the athletic directors, and $1,000.00 for Science Fair expenses, in addition to the $7,000.00 appropriated to the Public Relations Committee by the Council at its October, 1956, meeting. On motion of Drs. Owsley and Dudding, the Council voted the Public Relations Committee an additional $1,500.00 to cover 1957 expenses.

1957 ANNUAL CONVENTION AT FRENCH LICK

1. *Dates.* Monday, Tuesday and Wednesday, October 7, 8 and 9, 1957.

2. *Budget.* Dr. Stover, member of the Convention Arrangements Committee, read a letter from Dr. Ray H. Burnikel, chairman of the committee, in which he asked for a budget of $5,800.00 for the 1957 convention.

Dr. Paris made the motion, seconded by Dr. Dudding, that this request for $5,800.00 be granted.

Dr. Glock offered an amendment, which was accepted, to allow "an amount of money equal to the amount spent on golf, trap and skeet, for attendance prizes, for attendance at the clinical sessions." (This amount, as enumerated by Dr. Stover, will be $450.00).

On voting, the amended motion was carried, giving the Convention Arrangements Committee a budget of $6,250.00 for the 1957 convention.

3. *Scientific program.* Mr. Waggener announced that the Scientific Work Committee had held one meeting and would meet again early in February. It is the consensus of the committee that general scientific meetings, rather than a number of round table discussions, should be held at French Lick. Instructional courses will be held as usual on Monday.

4. *Scientific exhibit.* On motion of Drs. Paris and Owsley, a budget of $1,200.00 was approved for the Committee on Scientific Exhibits.

MEMBERSHIP PROBLEMS

1. 1956 Membership Report by Districts:

MEMBERSHIP REPORT

Indiana State Medical Association, December 31, 1956

County Society	No. M.D.'s in County	Members Dec. 31, 1956	Members Dec. 31, 1955	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
1st District									
Posey	14	12	12	--	2	--	2	--	--
Vanderburgh	219	201	196	5	9	10	15	3	2
Warrick	17	10	12	-2	3	--	5	3	--
Spencer	11	9	9	--	--	--	3	1	--
Perry	11	11	10	-1	--	--	--	--	--
Gibson	19	18	20	-2	1	--	2	--	--
Pike	5	5	6	-1	--	--	--	--	--
Total	296	266	265	1	15	10	27	7	2
2nd District									
Knox	43	39	39	--	2	--	2	2	--
Daviess-Martin	28	26	26	--	2	--	2	1	--
Sullivan	15	15	14	-1	--	1	1	--	--
Greene	19	19	19	--	--	1	--	--	--
*Owen-Monroe	58	55	52	3	3	2	1	2	--
Total	163	154	150	4	7	4	6	5	--
3rd District									
Lawrence	31	26	25	-1	--	1	4	2	--
Orange	12	9	9	--	3	--	--	--	--
*Harrison-Crawford	15	14	13	1	1	1	--	--	--
Washington	7	7	8	-1	--	--	1	--	--
Scott	5	3	3	--	1	--	1	--	--
Clark	34	30	30	--	3	1	3	1	--
*Floyd	38	38	36	2	--	--	--	--	--
*Dubois	21	20	20	--	1	1	3	--	--
Total	163	147	144	3	9	4	12	3	--
4th District									
Bartholomew-Brown	38	35	35	--	1	--	2	--	1
Jackson	23	22	20	2	--	--	--	2	--
Decatur	16	12	12	--	2	--	1	1	--
*Jennings	10	10	9	1	--	1	2	1	--
*Ripley	15	13	14	-1	2	--	--	--	--
Jefferson-Switzerland	32	28	24	4	3	2	5	--	--
*Dearborn-Ohio	15	14	14	--	--	--	--	1	1
Total	149	134	128	6	8	3	10	5	2
5th District									
*Parke-Vermillion	27	23	18	5	2	--	4	--	--
*Putnam	17	16	16	--	1	1	1	--	--
Vigo	124	119	123	4	1	3	8	3	1
Clay	15	13	12	1	--	--	3	--	--
Total	183	171	169	2	4	4	16	3	1
6th District									
Hancock	18	18	17	-1	--	--	1	--	--
*Henry	40	38	39	-1	2	1	1	--	--
*Wayne-Union	90	80	78	2	3	2	7	--	3
Rush	17	16	16	--	--	--	2	--	--
Fayette-Franklin	25	24	24	--	--	--	1	1	--
Shelby	22	20	19	1	--	1	2	2	--
Total	212	196	193	3	5	4	14	3	3
7th District									
*Hendricks	18	17	17	--	--	--	--	--	1
*Marion	1052	969	952	17	58	82	68	16	10
Morgan	18	14	17	-3	2	2	1	1	--
Johnson	27	24	22	2	2	3	1	1	--
Total	1115	1024	1008	16	62	87	70	18	11
8th District									
*Madison	112	106	102	4	3	2	3	2	2
*Delaware-Blackford	122	109	101	8	9	9	2	2	2
Jay	20	18	18	--	2	--	1	--	--
Randolph	25	23	23	--	1	--	1	--	--
Total	279	256	244	12	15	11	7	4	4
9th District									
Benton	9	7	8	-1	2	--	--	--	--
Fountain-Warren	16	16	16	--	--	1	1	--	--
*Tippecanoe	103	92	92	--	10	1	9	1	--
*Montgomery	31	29	30	-1	--	--	3	--	--
Clinton	25	24	23	1	--	1	--	2	--
Tipton	15	12	12	--	--	--	2	2	--
Boone	24	20	21	-1	3	1	1	--	--
Hamilton	23	20	18	2	1	2	2	--	1
White	12	11	10	1	--	--	--	--	1
Total	258	231	230	1	16	6	18	5	2
10th District									
*Lake	380	361	360	1	9	14	31	6	2
*Porter	32	32	33	-1	--	1	3	2	--
Jasper-Newton	21	18	19	-1	--	2	3	1	--
Total	433	411	412	-1	9	17	37	9	2

County Society	No. M.D.'s in County	Members Dec. 31, 1956	Members Dec. 31, 1955	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
11th District									
Carroll	10	10	9	1	--	--	--	--	--
Cass	49	41	36	5	6	--	7	1	2
*Miami	26	21	22	–1	3	1	2	--	1
Wabash	26	21	23	–2	3	1	3	--	--
Huntington	24	23	20	3	--	--	--	--	--
Howard	51	47	45	2	--	1	4	2	2
*Grant	70	57	55	2	10	2	2	1	--
Total	256	220	210	10	22	5	18	4	5
12th District									
LaGrange	9	9	9	--	--	--	--	1	--
Steuben	15	13	13	--	1	--	1	--	--
Noble	27	26	24	–2	1	2	3	--	--
DeKalb	21	20	20	--	1	--	2	--	--
*Whitley	16	13	11	2	3	2	--	--	--
Allen	248	240	236	4	5	8	13	6	4
Wells	39	34	29	–5	3	6	4	--	--
*Adams	16	15	15	--	--	1	--	--	--
Total	391	370	357	13	14	19	23	7	4
13th District									
LaPorte	90	87	92	5	5	3	10	1	--
*Elkhart	101	95	93	2	2	4	5	2	--
St. Joseph	243	223	219	4	13	6	13	2	3
*Starke	7	7	8	–1	--	--	--	--	--
Pulaski	7	6	5	1	1	--	--	--	--
Fulton	12	12	13	–1	--	--	--	--	--
Marshall	25	23	21	2	1	2	2	--	1
*Kosciusko	18	15	14	1	2	1	2	1	--
Total	503	468	465	3	24	16	32	6	4

SUMMARY BY DISTRICTS

1st District	296	266	265	1	15	10	27	7	2
2nd District	163	154	150	4	7	4	6	5	--
3rd District	163	147	144	3	9	4	12	3	--
4th District	149	134	128	6	8	3	10	5	2
5th District	183	171	169	2	4	4	16	3	1
6th District	212	196	193	3	5	4	14	3	3
7th District	1115	1024	1008	16	62	87	70	18	11
8th District	279	256	244	12	15	11	7	4	4
9th District	258	231	230	1	16	6	18	5	2
10th District	433	411	412	–1	9	17	37	9	2
11th District	256	220	210	10	22	5	18	4	5
12th District	391	370	357	13	14	19	23	7	4
13th District	503	468	465	3	24	16	32	6	4
Total	4401	4048	3975	73	210	190	290	79	39

* Physicians are listed in the counties in which they hold membership; not in the counties in which they reside.

92 physicians received membership gratis in 1956 because of military service

288 physicians were senior members in 1956.

2 physicians were honorary members in 1956.

149 physicians paid dues of $10.00 in 1956 as interns and residents.

74 physicians had their dues remitted by the Council in 1956.

Remission of state dues. On motions of Drs. Everly, Dudding and Ross, requests from Marion and St. Joseph counties for remission of state dues of two members, one because of illness, and the other because of retirement from practice, were approved.

LEGISLATIVE MATTERS

1. *Dr. Don Wood*, co-chairman of the Legislative Committee, spoke of the activities of his committee in holding meetings with the legislators, the State Chamber of Commerce, the Governor and his staff. He announced that his committee had decided to send to all county society secretaries in the state and to the members of the Legislative Committee the Daily Legislative Bulletin which is published by the State Chamber of Commerce. "We felt that each county secretary would be able to keep abreast of what was going on in the Legislature and it would keep your committee well informed as to the progress of these bills."

Following discussion by Drs. Glock, Wood, Ross and Mr. Waggener, on motion of Drs. Ross and Larson the Council voted to send the Daily Legislative Bulletin of the State Chamber of Commerce to the members of the Council, in addition to those named above.

2. *Fee for insanity inquests.* Dr. Vye stated that he had been instructed by the Council of the Lake County Medical Society "to get an opinion or a motion or something on fees for insanity inquests." He explained that the fees for which physicians in Lake County are doing insanity inquests were set in the 1920's, or earlier.

Discussed by Drs. Wood, Glock, Wilder, Dudding, Crowder, Paris, Larson, Nafe, Mr. Stump and Mr. Waggener. On motion of Drs. Dudding and Vye, the Council instructed the Legislative Committee to proceed as they think best in this matter to see if some change can be made in the present law, using their own discretion as to what fee should be set. The Council suggested that the Legislative Committee consult with the Committee on Mental Health for advice along this line.

3. *Key legislative representatives.* At the request of the A.M.A. Board of Trustees that each state appoint key legislative men in the various areas of each state, who would have the entire responsibility of carrying on the federal legislative contact work in conjunction with the Legislative Committee of the A.M.A., the Council, by consent, decided that the councilors should serve in this capacity, if the councilor of each district does not designate some other member. Members other than councilors designated for this work are:

Third District —Frederick K. Allen, New Albany

Seventh District—Don E. Wood, Indianapolis
J. Wm. Wright, Sr., Indianapolis

Tenth District —Philip J. Rosenbloom, Gary

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1. Locket, S.: Brit. M.J. *1*:809 (Apr. 2) 1955.

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2. Wright, W.T., Jr., et al.: J. Kansas M. Soc. *57*:410 (July) 1956.

Dosage: Merely two 2 mg. tablets at bedtime. After full effect one tablet suffices.

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In severe, otherwise intractable hypertension this single-tablet combination provides smoother, less erratic response to hexamethonium. Each tablet contains 1 mg. Rauwiloid and 250 mg. hexamethonium chloride dihydrate. Initial dose, ½ tablet q.i.d.

Riker LOS ANGELES

ECONOMIC AND ORGANIZATION MATTERS

1. *Parke-Vermillion County Medical Society Charter.* Records in the headquarters office show that Charter No. 89 was issued to Parke County Medical Society May 12, 1911, and Charter No. 62 was issued to Vermillion County Medical society April 20, 1904. These two societies are now consolidated into one society. The Constitution and Bylaws submitted by the Parke-Vermillion County Medical Society for approval were reviewed by Mr. Stump and found to be in conformity with the Constitution and Bylaws of the Indiana State Medical Association. The Council, therefore, on motion of Drs. Topping and Dudding, authorized the issuance of a charter to the Parke-Vermillion County Medical Society.

2. *County Society Officers Conference.* The suggestion of the Committee on Conference of Medical Society Officers that the conference of county medical society officers be replaced by an indoctrination program for all new members of the Association, to be held at the time of the annual convention, was presented to the Council with the recommendation of the Executive Committee that such an arrangement be approved.

The specific suggestions of the Committee on Conference of Medical Society Officers follow:

> "We have decided to recommend to the January meeting of the Council that the 1957 Conference **not be held.** In its place we are suggesting a three-point program to accomplish the ends which the Conference was originally designed to accomplish. The recommendations are:
>
> "1. That a time be set in the annual meeting in the Fall for a meeting of the County Medical Society Officers.
>
> "2. That a geographically, centrally located type conference be held each year in five or six places around the state at which the local Medical Society Officers will have an opportunity to discuss informally with the officers of the State Association the various problems. A few years ago these were held with great success.
>
> "3. The instigation of a definite orientation program for men opening practice each year. The suggested method of accomplishing this would be to invite the newly established physicians and their wives as guests of the Association to a luncheon during the State Convention and after some remarks by the President of the Association that the wives be asked to meet with members of the Auxiliary for their indoctrination and that the doctors themselves be indoctrinated by members of the Association as to the function of organized medicine and its subdivisions and likewise the responsibility of the physician to organized medicine."

On motion of Drs. Glock and Dudding the Council accepted the recommendation of the Executive Committee, with the stipulation "that this be tried out for one year as a trial study."

NEW BUSINESS

1. *Matters referred to Council by Executive Committee:*

a. Proposed legislation requiring that a coroner be a physician as a qualification to hold the office. Mr. Hollowell discussed this matter, as follows:

> "The situation is this: A coroner is a constitutional officer and the Constitution states his qualifications and, in those circumstances, the Legislature cannot add to nor detract from those qualifications—period. And one of the qualifications is not that he be a physician.
>
> "That gives us two roads to go: One is a constitutional amendment, adding that as a qualification. The other would be a statute which would create some new office such as Medical Director, or whatever you might want to call him, and then put all of the powers of the coroner that are desired in this new officer, leaving the coroner an office in name only. Well, he also serves process, and that would be about the only thing that would be left. That is a matter that would take a little bit of thought. It would be a new situation and how you are being to handle it is a type of matter that I think would require some thought as to what you want to do about it.
>
> "Those are the only two alternatives that I can see to the situation, starting with the premise that you just can't add the qualification by statute.
>
> "There is another thing to be thought about: We have certain offices now where you have to be a physician and, in some instances, it is almost impossible to get a physican to take the job. I think it is a greater problem in some counties than others. So, if we start down the road, we might want to know whether we are going to be able to furnish people to fill that office in 92 counties in the state.
>
> "Those are problems that, it seems to me, need a little more study than just to sit down and write a bill or a constitutional amendment. A constitutional amendment has to pass two sessions of the Legislature and then be voted on. In other words, the shortest period of time is six years."

This matter was discussed also by Drs. Clarke, Owsley, Dudding and Dodds, following which the chairman announced the appointment of a committee to study this subject and report back to the Council at a later date. Committee members are:

Edward B. Smith, M.D., Chairman, Indianapolis
Lall G. Montgomery, M.D., Muncie
Russell P. Reynolds, M.D., Garrett
Joseph E. Dudding, M.D., Hope

b. *Contribution for relief of Hungarian physicians.* A poll taken by the headquarters office of the Council showed eight members in favor of the Association giving $500.00 to the Relief Fund for Hungarian physicians, four in favor of $1,000.00, and one "No." The Executive Committee, at its meeting on January 19, 1957, voted to recommend to the Council that $500.00 be appropriated to this relief fund. On motion of Drs. Crowder and Clarke, the Council approved this recommendation.

2. *Employment of a Ph.D. in a physician's office.* Inquiry received from a physician asking if employment of a Ph.D. "whose duties are to obtain social histories, do psychometrics and administer aptitude and other educational evaluations" is approved, was presented to the Council. The letter continues: "Our personal opinion is that she functions in our office as a laboratory technician would in an internist's office. . . . We await your decision and our letter is prompted by the action of the

House of Delegates regarding the association of an ophthalmologist and optometrist in one office."

Following discussion by Drs. Owsley and Denny, it was taken by consent that the Council should write the Judicial Council of the American Medical Association for an opinion in this matter.

3. *State Board of Health matters.* Dr. Offutt appeared before the Council to speak on:

(1) Dental program that has been set up at the federal level for the study of the situation in regard to dental care among (a) the chronically ill, and (b) the aged.

Dr. Offutt: "Now, there is nothing that I can find that says that to be chronically ill you have to be above twenty-one, so that chronically ill people will apparently encompass the whole society. The aged is a little more clear.

"This problem, which I know to be a problem, has existed for some time and we do not know the exact magnitude of the problem.

"The program which is established consists of two parts, generally:

"1. To determine what this dental problem actually is. This involves the actual study of people in institutions for these two classes of people, to find out how many of them need dentures, how many need oral surgery and all the various things that would go to production of good dental health.

"After such a study is made in the institutions—and that is mental institutions, county farms, nursing homes—then that same study would be made in your home. In other words, we would knock at your door and ask you, 'Whom do you have in the house, chronically ill, and do they need dental care?' This, of course, will not be done free. It will undoubtedly be labeled as a free program but it will be anything but that.

"2. Now, the second segment of the program is this: That after the study is made and the extent of the problem is known, then clinics will be established and these people will be brought to the clinic for the necessary treatment. That means extractions, fillings, bridgework, or anything that has to be done.

"The dentists who will be provided to do this will be from the United States Public Health Service. The administration of the program will be in your State Board of Health, together with the Dental School here on the campus.

"This latter half of the program as planned today will simply be within the confines of Marion county. In other words, they do not propose at this time to go into any other county other than Marion.

"My own Board has approved, in principle, Part 1, which is simply the measurement of the problem of dental care, and they very carefully withheld any action on Part 2."

Dr. Offutt asked for the advice of the Council and how the members felt about this matter, "recognizing that this is dentistry but, by the same token, it is a little different sort of thing."

Following discussion by Drs. Dudding, Ross, Wilder and Crowder, Dr. Glock moved that "the Council go on record as disapproving the type of program under the second paragraph," that is, the institution of clinics. Motion seconded by Dr. Owsley. Dr. Owsley then proposed an amendment to the motion "to disapprove the whole thing. I don't see what good Part 1 is if you don't have Part 2." The amendment was accepted by Dr. Glock. The amended motion was seconded by Dr. Dudding, put to vote, and carried.

(2) The polio program. This was discussed by Drs. Offutt, Crowder, Everly and Clarke. Dr. Offutt then asked for an expression from the Council on sending out the following letter to all county and city school superintendents and county health officers, and especially if there was any objection to the five points listed:

TO: ALL COUNTY AND CITY SUPERINTENDENTS
FROM: A. C. OFFUTT, M.D.
STATE HEALTH COMMISSIONER
and
WILBUR YOUNG
SUPERINTENDENT OF PUBLIC INSTRUCTION

In the spring of 1955, following the successful Salk vaccine field trials, we appealed to you for help in bringing protection against paralytic poliomyelitis to all 1st and 2nd grade pupils of the State. We are happy to report that 90%, or 220,000 of the 1st and 2nd grade pupils received their first shots; 85% their 2nd shots. There is no information as to the number that received the full series or the 3rd shot.

Salk vaccine is one of the safest of all vaccines. 15,000,000 children have been vaccinated with exceeding rare and minimal reaction.

At the time when there was an inadequate supply of the vaccine, people were clamoring for it. Now, there is no problem of supply but many of those between the ages of 1 and 40, when protection is most needed, are not being vaccinated.

The schools of Indiana can do much to overcome this apathy. We feel sure that you will want to do all in your power to encourage the people of your community, school age children in particular, to be protected against poliomyelitis.

Some of the activities that might be undertaken are:

1. Determine the extent of previous vaccination by survey. This data is valuable for program planning.
2. In-service education for teachers concerning immunization.
3. Letters to parents giving basic information and encouraging them to have children vaccinated.
4. Promote program through school and community health councils, PTA, teacher meetings, etc.
5. Special programs on Salk vaccine in home rooms, convocations.

We realize the suggestions offered are familiar to you and have been utilized upon many occasions in the past. However, we hope that progress for vaccination against paralytic poliomyelitis for children and adults will be included in your school health activities.

It would be well to discuss this problem with the local medical society and health officers. The State

Department of Public Instruction and State Board of Health offer their assistance.

On motion of Drs. Everly and Owsley, the Council approved the above letter.

On motion of Drs. Ross and Dudding, the Council went on record as expressing its appreciation for Dr. Offutt's appearance before the Council and for the information he had given.

4. *Proposed revision of the A. M. A. Code of Ethics.* This subject was discussed by Drs. Stover and Jones, in reporting on the Seattle clinical session earlier in the Council meeting. At this time Mr. Waggener reminded the Council that the A.M.A. is again seeking suggestions from the physicians and the states as to what to do about the following two controversial sections, and suggested that the Council might want to give some consideration to this matter at its next meeting. "You might want to officially make some recommendations to the Council on Constitution and Bylaws of the A.M.A. as to the thinking of the Indiana physicians on those two sections."

Section 6: A physician should not dispose of his services under terms and conditions which will interfere with or impair the present and complete exercise of his independent medical judgment or skill or cause a deterioration of the quality of medical care.

Section 7: In the practice of medicine, a physician should limit the source of his professional income to medical services actually rendered by him to his patient.

5. *Nominations for membership on Board of Directors of Mutual Medical Insurance, Inc.* On motion of Drs. Larson, Owsley, and Glock, the Council accepted the following district nominations for membership on the Board of Directors of Blue Shield, to fill vacancies occuring at the expiration of terms in March, 1957:

C. Philip Fox, Washington —Second District
John M. Paris, New Albany—Third District
Walter U. Kennedy,
New Castle —Sixth District
John A. Bowers, Kokomo —Eleventh District

Dr. Ross made the motion that the Council recommend to the Blue Shield Board that the three members at large, whose terms expire in March of this year—Drs. W. L. Portteus, Cleon A. Nafe and J. E. Pilcher—be retained. Motion not seconded.

Following discussion by Drs. Glock, Clarke, Owsley, Denny and Larson, on motion of Drs. Glock and Owsley the Council deferred action on this matter until the next meeting of the Council.

On motion of Dr. Owsley, duly seconded, the chairman of the Council appointed a committee to study this matter, and to report back to the Council, as follows: Dr. Owsley, chairman, and Drs. Glock and Everly.

6. *Resolution adopted by St. Joseph County Medical Society,* asking that the Council initiate the necessary action to place a representative of the St. Joseph County Medical Society on the Board of Directors of Blue Shield, was discussed by Drs. Larson, Glock, Dudding, Topping and Clarke.

Drs. Larson and Glock moved that the recommendation of the St. Joseph County Medical Society be approved and that it be referred to the above-named study committee of the Council. On voice vote this motion was lost.

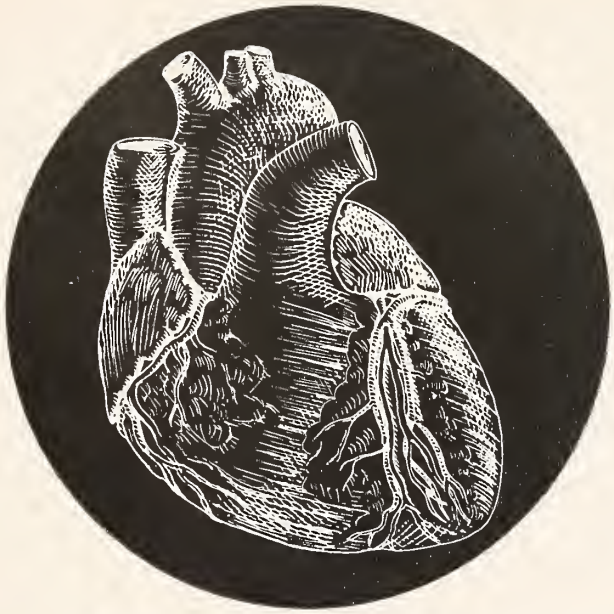
6. *Spring meeting of the Council.* By consent, April 28, 1957, was set for the spring Council meeting, at the Indiana University Student Union Building, Indianapolis.

7. *Northern Indiana Children's Hospital.* On motion of Drs. Larson and Owsley, the Council voted to "direct the Legislative Committee to oppose any such move as closing the Children's Hospital of Northern Indiana at South Bend." This action was taken following announcement by Dr. Larson that the present administration is considering closing this hospital as an economy move.

ELECTION OF CHAIRMAN OF THE COUNCIL

By ballot vote, Dr. Guy A. Owsley, Hartford City, was elected chairman of the Council for 1957, to replace Dr. Wemple Dodds, Crawfordsville, resigned.

There being no further business, the meeting was adjourned.



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District Meeting Reports

SIXTH COUNCILOR DISTRICT

The Sixth District Medical Society will meet at Liberty, Union County, on Thursday, May 9.

The regular business meeting will be held in the Liberty Public Library at 10:30 a.m. after which a fried chicken luncheon will be served at Dunlapsville, famed for fried chicken, and located four miles from Liberty.

The scientific session will be held at 2 p.m. in the Liberty Public Library. Drs. Bernard Rosenak and Stanley Battersby, both of Indianapolis, will speak on the medical and surgical aspects of massive gastrointestinal bleeding.

Adjournment is planned for 4 p.m. All events are scheduled on fast time, Eastern Standard. All Indiana physicians are invited to attend the Sixth District meeting.

ELEVENTH COUNCILOR DISTRICT

All county medical society presidents in the Eleventh Councilor District have been advised of a committee meeting to be held on April 3, in the Bearss Hotel, Peru, at 6:30 p.m., at which time a Budget Committee will attempt to settle the question of district society dues so a recommendation and/or amendment to a motion to set district dues at $10.00 per year can be presented at the Spring meeting of the District Society on May 15.

Dr. Earl W. Bailey, Eleventh District President, has named as the Budget Committee, each county society president or his direct delegate to resolve the dues matter. Dr. T. W. Omstead, Huntington, immediate past president, will act as chairman for the April 3 meeting.

News from the County Societies

Dr. C. G. Kern, Lebanon, reviewed a recent Cancer Society film on "Self Examination of the Breast" at the February 5, evening meeting of **Boone County Medical Society** in the Witham Memorial Hospital, Lebanon.

Fifteen members attended the meeting and during the business session voted to cooperate with Purdue University's cardiac project in which a survey is being made of farmers with cardiac conditions followed by research to determine the effect of farm work on the heart and possible means of lightening the work load.

Twenty-six members of **Cass County Medical Society** recently heard Dr. Richard Nay, Indianapolis, speak on "Congestive Heart Failure." The dinner meeting was held in the Ben Hur Motel on January 7.

Clark County Medical Society members held an evening meeting January 15, in Clark County Memorial Hospital, Jeffersonville, with 14 members present. Business affairs of the society were discussed and an agreement reached on average fees for office, house and night calls.

Dr. William W. Murray, Madison State Hospital, discussed "Admissions, Uses and Abuses of State Mental Hospitals" at an 8:30 a.m. meeting of **Decatur County Medical Society** in the Decatur County Memorial Hospital, Greensburg, on January 16. Seven members attended the meeting.

A combined meeting of the **Elkhart County Medical Society** and the Woman's Auxiliary

was held January 3, with 130 persons attending the dinner in the Hotel Elkhart. The heavy attendance indicated approval of the joint meeting plan.

Dr. Walter C. Alvarez, Chicago, was the guest speaker. He discussed "How People Make Themselves Ill" and developed his subject from both scientific and humorous angles.

An x-ray seminar under the direction of Dr. C. L. Poston was the program for the January 8 meeting of **Fayette-Franklin County Medical Society.** Seventeen members attended the dinner meeting in the Connersville Country Club.

A motion picture on the "Use of Heparin" was shown at the meeting of the **Fountain-Warren County Medical Society** in the Attica Hotel February 7. Eight members attended the dinner meeting.

A committee was appointed to study polio immunization in the presently unvaccinated population and to evaluate pressure for free immunizations.

A general business meeting of the **Henry County Medical Society** was held in the Henry County Hospital in New Castle January 17, with 20 members attending the evening meeting.

Plans for the year were made at the January 9, meeting of **Johnson County Medical Society** in the Johnson County Memorial Hospital in Franklin. Sixteen members participated in the general discussion and planning.

Public relations committee members of the **Knox County Medical Society** made their annual report to the society at a meeting January 15 in the Grand Hotel, Vincennes. Nineteen members attended the dinner and later made plans for a joint meeting with the Woman's Auxiliary.

Thirty-five members of **Laporte County Medical Society** and the Woman's Auxiliary attended a dinner meeting in the Hotel Rumely, LaPorte, on January 17. Separate meetings of the two groups followed the dinner.

Dr. Sigmund Winton, Chicago, presented an excellent paper on the "Basis of Antibiotic Therapy" to the physicians.

The legislative committee of the society reported they had urged their representative in the Indiana General Assembly to consider the needs of the Northern Indiana Children's Hospital when the budget was under discussion. They also sent a resolution to the superintendent of the hospital at South Bend stating opposition to any curtailment of funds for the hospital which would affect its operation. The society was of the opinion that the facilities were necessary for proper pediatric care in the area.

Auxiliary members were entertained by members of the local radio station staff.

Dr. C. J. McIntyre, Indianapolis, was the guest speaker at the **Lawrence County Medical Society** meeting on February 6. He spoke on "The Use of Radioactive Materials Medically."

The meeting was held in Dunn Memorial Hospital, Bedford. Nineteen members attended and took special action in support of the right-to-work legislation. Letters were sent to their state representative, senator and to the governor.

Dr. Frank Gerbode, chief of Stanford University's department of surgery, spoke on "Surgical Treatment for Occlusive Disease of the Aorta with Particular Reference to Diagnosis and Clinical Evaluation" before 225 members of **Indianapolis (Marion County) Medical Society** on January 22 in the Empire Life Auditorium. The guest speaker was introduced by Dr. Harris B. Shumacker.

Membership applications had been approved and the following seven physicians were elected to membership: Drs. Morris W. Dickey, Warren L. Kilmer, William M. Hurteau, Louis L. Weiss, Arthur Baptisti, Jesse D. Hubbard and John E. Mahaffey.

A memorial tribute to Dr. Benjamin F. Hatfield was read by Dr. Wendell Brown, chairman of a committee with Drs. Ralph Lochry and Henry Nolting.

Please turn to page 378

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Dr. James Leffel presided at the meeting. A buffet supper was enjoyed following the scientific program.

A special meeting of the society was called for February 12 for the purpose of discussing a polio immunization program in Marion County. Dr. James M. Leffel, president, was in charge of the meeting and Dr. Harry Pandolfo, chairman of the special polio committee, outlined the proposed plans for a county-wide immunization campaign. Final decision on plans established a definite campaign of educational publicity releases, the use of radio and TV, immunization centers in every doctor's office for a six-week period from February 19 through March 31 and assurance was given that no one would be denied polio immunization because of inability to pay. A plan was proposed by Dr. Richard Dyke to have indigents immunized at Indianapolis General Hospital where facilities and staff would be available.

The following physicians were elected to membership at the special meeting: Drs. Carl A. Freed, transfer from Fountain County; Julius M. Klaus, from Lake County; Emmett C. Pierce, from Fountain County; George N. Porter, Ross W. Lambert, David B. Kenney, William P. Henderson, Donald M. Rohrbacker, Verne K. Harvey, Jr., and Max T. Taylor.

Dr. John A. Crawford, Indianapolis, was the guest speaker at the January 17 meeting of the **Montgomery County Medical Society.** He gave a paper on "Neck, Shoulder and Arm Pain".

Drs. Claude N. Thompson and Allen D. Pierson were accepted as new members of the society.

Twenty-six members attended the meeting in Culver Union Hospital, Crawfordsville.

Dr. Matthew Winters, formerly of Indianapolis and now a resident of Bloomington, spoke on "Changes in 36 Years of Pediatric Practice" at the January 31 meeting of the **Owen-Monroe County Medical Society** in the Bloomington Country Club. Thirty members attended the meeting.

Parke-Vermillion County Medical Society members met for dinner January 16 in the Vermillion County Hospital, Clinton, with Dr. John A. Campbell, Indiana University Medical Center, as their guest speaker. He discussed "Use of Atomic Energy Products in the Treatment of Malignant Diseases". Twelve members attended the meeting.

The polio situation in their county and a publicity campaign to encourage immunization with Salk vaccine were discussed by 12 members of **Starke County Medical Society** at a meeting in the Board Room of the Starke Memorial Hospital, Knox, on January 8.

Dr. Ralph Eades, Valparaiso, discussed the Science Fair project with the Starke County Society at the February 5 meeting in the Starke Memorial Hospital. Nine members attended the dinner meeting.

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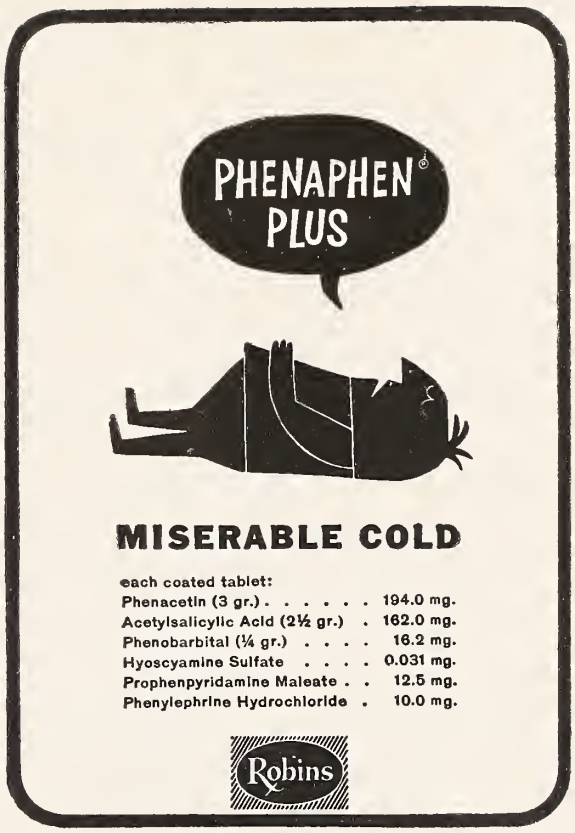
Eight members of **Wabash County Medical Society** held a dinner and business meeting in the Wabash Cafeteria February 6. The March meeting of the society was to be held in the Wabash Country Club.

In a special meeting January 29 the **Vanderburgh County Medical Society** voted to conduct a two-month campaign to inoculate as many citizens as possible with Salk anti-poliomyelitis vaccine. During the February and March drive all fees from vaccination will be reduced, private physicians will give the shots to anyone 1 to 19 unable to pay and three clinics will be set up at Evansville general hospitals. Members were asked to keep accurate records on all vaccinations to determine the percentage of the population receiving the shots during the special drive.

Plans were also announced for the joint meeting February 21 with the Indiana Academy of General Practice when a "Road Show" afternoon and evening program was to be presented in the Hotel McCurdy.



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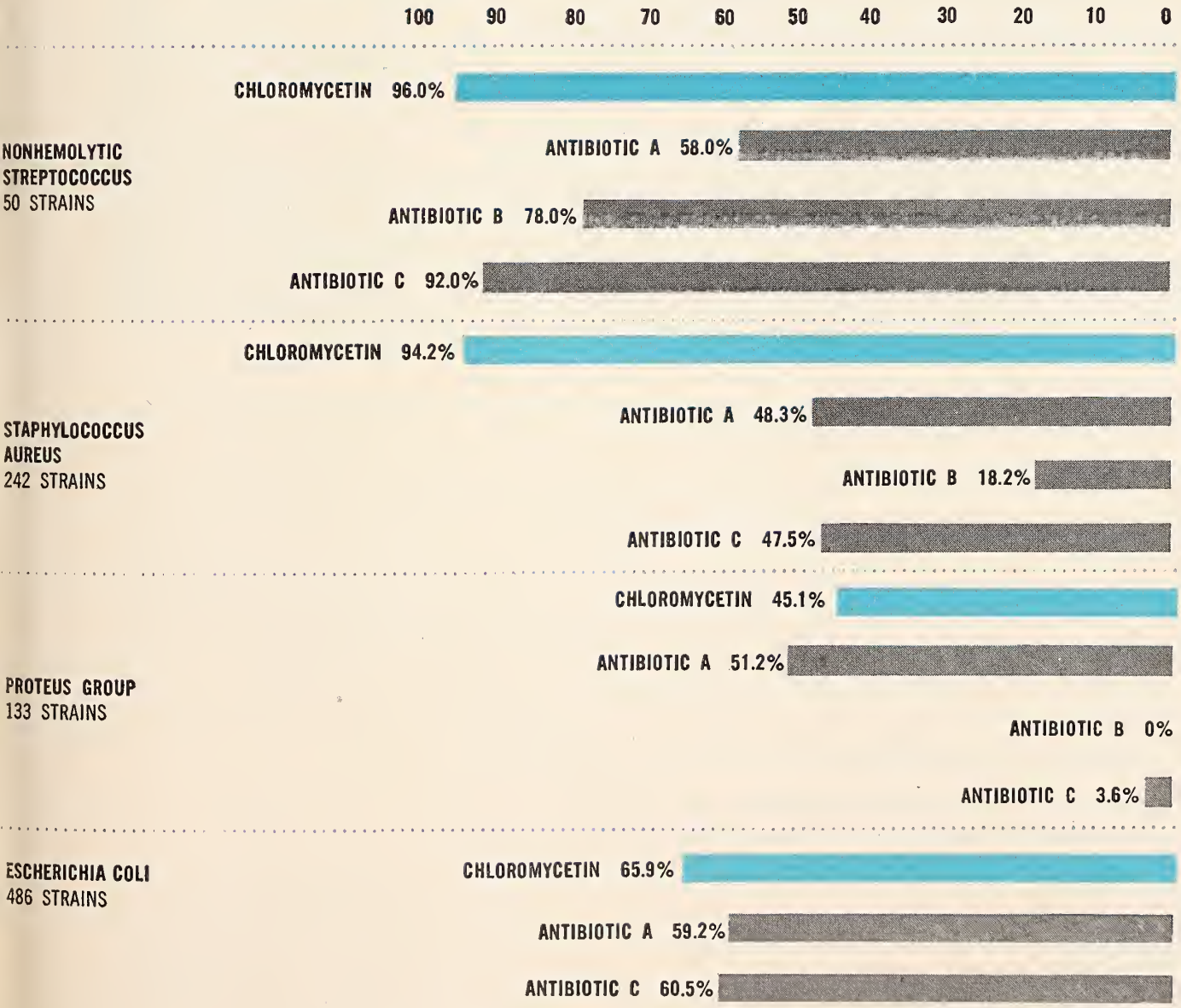

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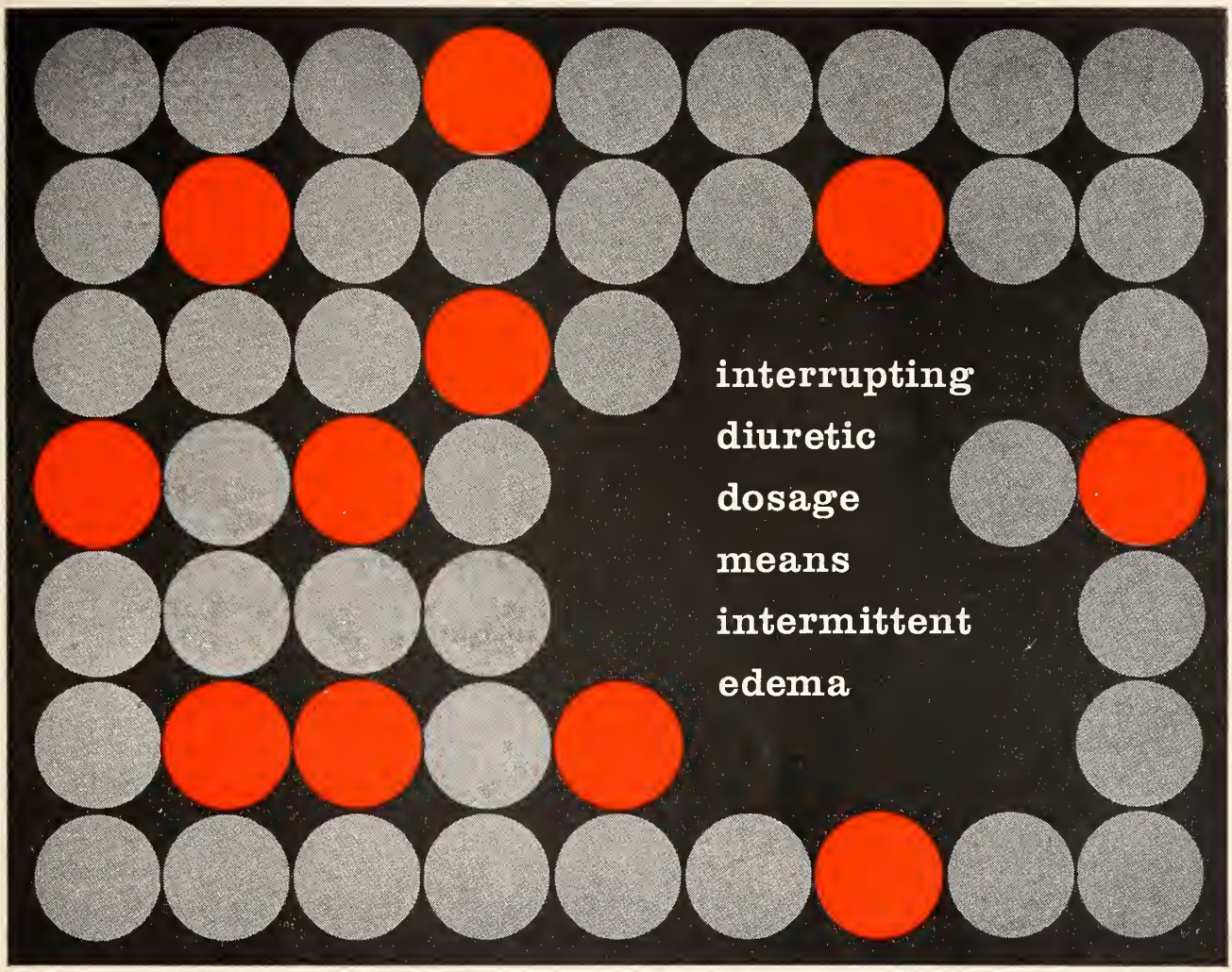

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2.	Sam I. Rotman, M.D., Jasonville	J. S. Brown, M.D., Carlisle	Linton, June 6, 1957
3.	Wm. H. Robinson, M.D., Mitchell	Joseph C. Dusard, M.D., Bedford	Bedford, May 15, 1957
4.	Winship C. Callaghan, M.D., Greensburg	Robert A. Porter, Westport	Greensburg, May 8, 1957
5.	C. M. Schauwecker, M.D., Greencastle	James B. Johnson, M.D., Greencastle	Terre Haute, May 23, 1957
6.	Frank H. Green, M.D., Rushville	J. Frank Lewis, M.D., Liberty	Liberty, May 9, 1957
7.	Joseph F. Ferrara, M.D., Franklin	Arthur W. Records, M.D., Franklin	
8.	F. W. McDowell, M.D., Muncie	Clyde G. Botkin, M.D., Muncie	Muncie, June 12, 1957
9.	J. A. Van Kirk, M.D., Frankfort	Dan Tucker Miller, M.D., Fowler	Fowler, May 23, 1957
10.	E. J. DeGrazia, M.D., Valparaiso	Wm. C. Robertson, M.D., Chesterton	May, 1957
11.	T. W. Omstead, M.D., Huntington	Charles L. Wise, M.D., Camden	Huntington, May 15, 1957
12.	C. Jules Heritier, M.D., Columbia City	Floyd B. Kantzer, M.D., Garrett	Pokagon State Park, May 15, 1957
13.	R. E. Nelson, M.D., South Bend	O. E. Wilson, M.D., Elkhart	South Bend, Nov. 20, 1957

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This summary of what is happening in Washington is prepared by A.M.A.'s capital office and airmailed to THE JOURNAL on the ninth of each month.

THE MONTH IN WASHINGTON

Washington, D. C. — The Army's Office of Dependent Medical Care, handling the new program that offers private medical care to service families, is working on some long- and some short-range plans of importance to state societies.

To meet a problem coming up in the next few months, the office is notifying states that contracts for physicians' services, negotiated through the state societies last fall, will be extended automatically when their expiration date of July 1 arrives. However, there is no definite time period set for any of the extensions; each contract will be continued in effect until that particular state's agreement has been renegotiated.

When the contract is extended, according to Maj. Gen. Paul I. Robinson, head of the Office of Dependent Medical Care, it will be possible to make necessary adjustments, but he hopes not too many changes will be asked at that time.

Then, after July 1, each state will be given 60 days' notification before Defense Department makes its final audit covering the period from December 7, 1956, when the program went into effect, through June 30, 1957. This audit has been promised in each state before renegotiation starts.

Both the state fiscal agents and General Robinson's staff should be well prepared for renegotiations when the time arrives. No renegotiations will be undertaken until January, 1958. They will continue for most of next year, on a tentative schedule that calls for handling about five contracts per month.

Under this tentative arrangement, the contract with the Indiana State Medical Association will be renegotiated during the month of March, 1958.

If any large-scale health and medical program is to be pushed through Congress this year, most of the pushing will be done by the Democrats, who, in control on Capitol Hill, can get what they want, in theory at least.

Announcing that the idea of a special presidential health message had been dropped for this year, Secretary Folsom also said the **Republican administration would press for only three major health-medical bills.** All three, incidentally, were before Congress last year but were not acted upon. They are:

1. Federal assistance to medical, dental, and public health schools to help them build and

Please turn to page 406

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frozen shoulder

Bursitis and tenosynovitis are new terms to homemakers, but they are not uncommon sequels to overexertion. Early antirheumatic therapy is to be encouraged in the treatment of these conditions, as it is in more serious rheumatic conditions, to alleviate pain and prevent progression of the disorder. With adequate therapy the prognosis of bursitis in its acute stage is good. Delaying therapy may result in extension of the inflammation and gross anatomical changes that tend to incapacitate the patient.

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2. Waiver of the anti-monoply laws to permit small companies (none doing more than one percent of the total business) to pool some of their funds for experimental work in expanding voluntary health insurance.

3. Authorization for construction of sanitary facilities on Indian reservations.

In outlining these legislative objectives of the administration, the Secretary took the opportunity to make clear he doesn't think much of one bill that has the ardent support of some Democrats and of some labor leaders. It would have the U. S. pay for 60 days' free hospitalization annually for persons aged 65 and over who are under social security, and their dependents if also over 65.

Mr. Folsom said the social security administration has all it can do administratively to put into effect the major amendments passed last year, and that besides the "hospitalization at 65" plan skirts so close to the area of compulsory health insurance that it should be regarded cautiously.

NOTES

A House committee, making a survey of the cost of veterans' programs, has been asked by VA Administrator Harvey Higley to ponder this question: **Should more VA hospitals be constructed** when we know beyond doubt that they will be largely for the benefit of non-service-connected cases?

As anticipated, pressure already is on Congress to **drop or lower the age 50 limit for OASI payments** because of disability. Many bills have been introduced on the subject.

Congressmen are hearing again from the **friends of the "Hoxsey cancer cure,"** which has been under constant attack by Food and Drug Administration but still manages to stay in business. Form cards, carrying space for a name and address, are being received on Capitol Hill, each asking Congress to investigate FDA for the way that agency has pressured the Hoxsey people.

An addition to the top echelon of the Department of Health, Education, and Welfare is a young (33) assistant to Secretary Folsom, who holds both medical and law degress. He is **Dr. Robert H. Hamlin**, of Brookline, Massachusetts. Another HEW addition is **John A. Perkins, Ph.D.**, president of the University of Delaware, the new Under Secretary.

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The Fourth Estate Looks at Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

"JUDGE . . . CALL SURGERY"

Hospitals everywhere set and maintain their own standards of medical and surgical practice . . . and the better the hospital, the higher the standards.

These concern technical medical matters only, and they are established, as they should be, by doctors acting on the combined judgment of the best professional talent of the hospital's whole staff.

The bill now pending in the Indiana Senate ostensibly to "let patients select their own doctors" or to "guarantee medical justice," actually proposes simply to substitute the judgment of politicians for the judgment of doctors on such purely medical questions.

It would transfer ultimate control over standards of hospital practice and qualifications of those engaged in it from the hospitals to the courts. It could compel a hospital to throw open its operating rooms and its laboratories and its entire technical facilities to any quack able to convince a court for use as he wished . . . under any standards, or no standards at all.

Courts are usually administered by lawyers whose combined professional judgment on questions of law quite properly determines the standards of legal practice . . . but only of legal practice. We doubt if any patient in his right mind would call in a judge, no matter how distinguished, to perform a major surgical operation. Any more than a party to a lawsuit would hire a physician to plead his case in court.

Such a statute as this would break down the standards of every hospital in Indiana. Its enactment would immediately jeopardize their accreditation by national authorities without which they no longer could give valid degrees to nurses they train, nor complete the training of internes and residents from medical schools. And that, conceivably, could shut down any hospital entirely.

This is a "grudge bill," plainly designed as retaliation against one Indianapolis hospital for one specific ruling on technical aspects of surgical procedure that no court, and no legislature, reasonably could be expected to understand.

Hearings so far held on it should by now have made it clear to the Senate Committee conducting them that its inception and all its support have come from one individual whose perhaps admirable loyalty to a personal friend concerned in that ruling appears to have obscured his vision of the harm it could do to Indiana.

It is not in any sense a proposal to "guarantee medical justice" or to give patients any greater choice of physicians than they already have . . . regardless of blatant propaganda to that effect.

At best this proposal is without any merit whatever.

Its potential for serious injury to every hospital in this state is immeasurable.

This is a bad bill.

The Senate committee will be well-advised to kill it and forget it.

—*The Indianapolis Times*

HOW ABOUT "JUSTICE" FOR EVERYBODY?

The backers, if, indeed, there are more than one, of Senate Bill 403, the hospital grudge bill to put politicians instead of doctors in charge of surgery, seem annoyed and even a little perturbed that the Indianapolis Medical Society overwhelmingly opposes it.

Obviously the bill's sponsor(s) have been so intent on what they keep calling "justice for doctors" they have overlooked the broader aspects and possibilities of the issue.

They might, we suggest, pick up a modicum of support by amending their proposal in the Indiana Senate, to apply its principles somewhat more extensively in the interest of "justice" for more people.

It could include, for example, a clause permitting anyone not satisfied with the decision of any court to appeal to a doctor of medicine who would have power to overrule the judge on any point of law. Same idea exactly and if it works with "justice" one way, it certainly ought to work the other.

Extending the identical principle of the present bill it could, with equal "justice," forbid any church to dismiss a pastor who perhaps took to preaching Buddhism from its pulpit and empower a political court to order any religious denomination to accept into its ministry any Voodoo priest or Shinto initiate who cared to apply, regardless of his religious beliefs, standards or practices.

This is precisely what Senate Bill 403 proposes to do for doctors and hospitals, claiming jurisdiction over private hospitals, by the way, on the grounds they are exempted from taxes. Since churches, also, are exempted from taxes that point need hardly give a moment's concern to our staunch and self-less battler(s) for "medical justice."

No doubt there are many other groups to which this kind of "justice" might also be extended if they just put their minds to it. Any principle that is good at all is universally good, and we don't feel

the application of this one ought to be so narrowly exclusive.

If this is a good bill that really does promote justice we feel the Senate should make it apply to everybody.

If, on the other hand, as all the evidence strongly indicates, it is a bad bill designed and promoted merely to satify somebody's personal spite against one institution . . . then the sooner the Senate can kill it, and forget, the better all round.

—*The Indianapolis Times*

DOCTORS' WALKOUT

The council of the British Medical Association has decided that the doctors should resign en masse from the government health service unless the government quits stalling on their demand for a 24 per cent increase in pay.

When British medicine was socialized a decade ago, the doctors were promised by the government that their pay would always assure them at least the pre-war living scale of 1939. The doctors have received no pay increases from the state health service since 1951, despite sharp increases in living costs.

If the British medical profession ever hopes to recapture its former liberty, the time would now seem to be opportune. The government has reneged on the promise that enticed all but about 500 British physicians to sign up with the state service.

Moreover, the cause of freedom against state domination would be advanced significantly, and it would occasion no suprise if another result of equal benefit would prove to be a material improvement in the standard of medical practice. When every patient is a number, ticked off at the same price per head, there is no particular reason for a doctor to deal with him except as a unit in an unending routine. A reversion to private responsibility would humanize the doctor-patient relationship and could work wonders for both participants.

—*Chicago Tribune*

The middle-aged man was standing on the bathroom scales, under protest, while his wife squinted at the weight indicator.

"Good heavens, John!" she exclaimed. "You have gained 57 lbs. since we were married! You should be ashamed!"

"Oh, I don't know," shrugged the quick-witted man. "Seems to me I've done remarkably well; when you average it out, it's only 3 lbs. a year, on your good cooking!"

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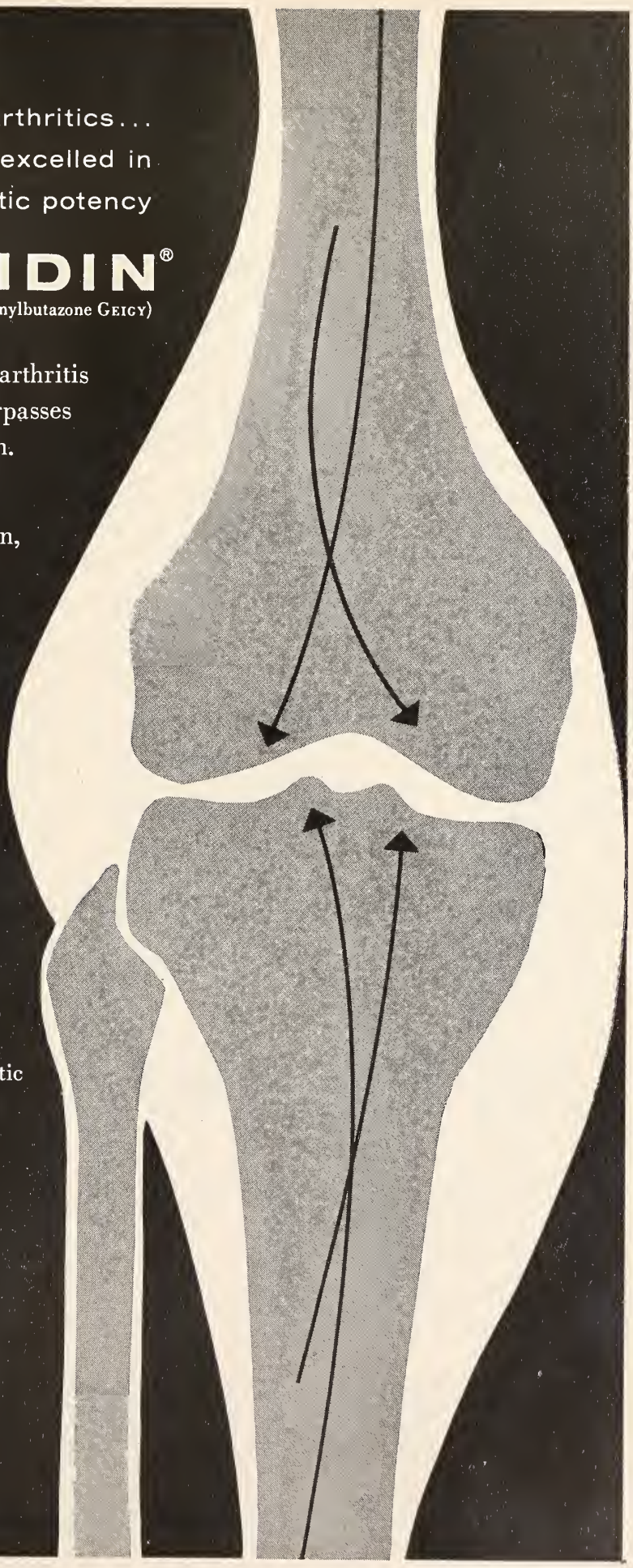


Wanted: PHYSICIANS LOCATIONS

The following list of physicians made inquiry during January and February concerning locations to practice in Indiana. No additional communities asked for assistance in securing the services of a physician.

Each physician listed has been sent a copy of the placement booklet, showing areas in the state where additional physicians are needed. Communities still needing physicians have been given this current list to contact.

John S. Wilson, M.D. (general practice), 1901 Harding Highway, Lima, Ohio.

Wilfred B. Dodgson, M.D. (general practice), 130th Station Hospital, APO 403, New York, New York.

Thomas A. Fedor, M.D. (general practice), Long Hospital, I. U. Medical Center, Indianapolis 7, Indiana.

Donald B. Garvin, M.D. (general practice), 601 Prairieview, Clovis, New Mexico.

Lloyd E. Appell, M.D. (general practice), 1412 West Drive, Larson AFB, Washington.

Robert L. Heins, M.D. (general practice), Battle Creek, Nebraska.

Edwin R. Davis, M.D. (general practice), 44 Hopeland St., Dayton 8, Ohio.

John J. Roget, M.D. (general practice), 351 Roth Road, Springfield, Ohio.

James Kaler, Jr., M.D. (general practice), American Legion Hospital, Battle Creek, Michigan.

Lauro R. Montemayer, M.D. (general practice), Post Surgeon, Ft. Amador, Panama Canal Zone.

Alexander Diduch, M.D. (general practice), Interne's Quarters, St. Boniface Hospital, St. Boniface, Manitoba.

Martin H. Perle, M.D. (orthopedic surgery), 122 56th St., West New York, New Jersey.

Alvin E. Berglund, M.D. (general and OB-GYN), OB-GYN Section—USA Hospital, Fort Riley, Kansas.

Aristides Cardona, M.D. (general surgery), 106 Sims Road, Syracuse, New York.

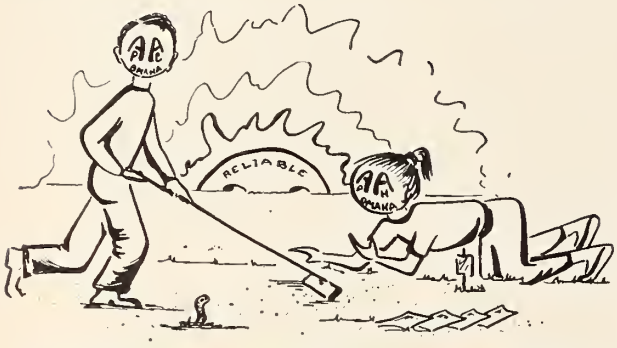
Frank E. Ferro, M.D. (thoracic surgery), Veterans Administration Hospital, Brecksville, Ohio.

Edward A. Scollin, M.D. (general surgery with general practice), Lynch Medical Service, Lynch, Kentucky.

Lawrence L. Luan, M.D. (internal medicine), 3140 S. Michigan Avenue, #502, Chicago 16, Illinois.

Karl E. Blake, M.D. (general surgery and part time industrial), 2681 Crosby Ave., Pittsburgh 16, Pa.

Lawrence Benken, M.D. (OB-GYN), I. U. Medical Center, Indianapolis 7, Indiana.



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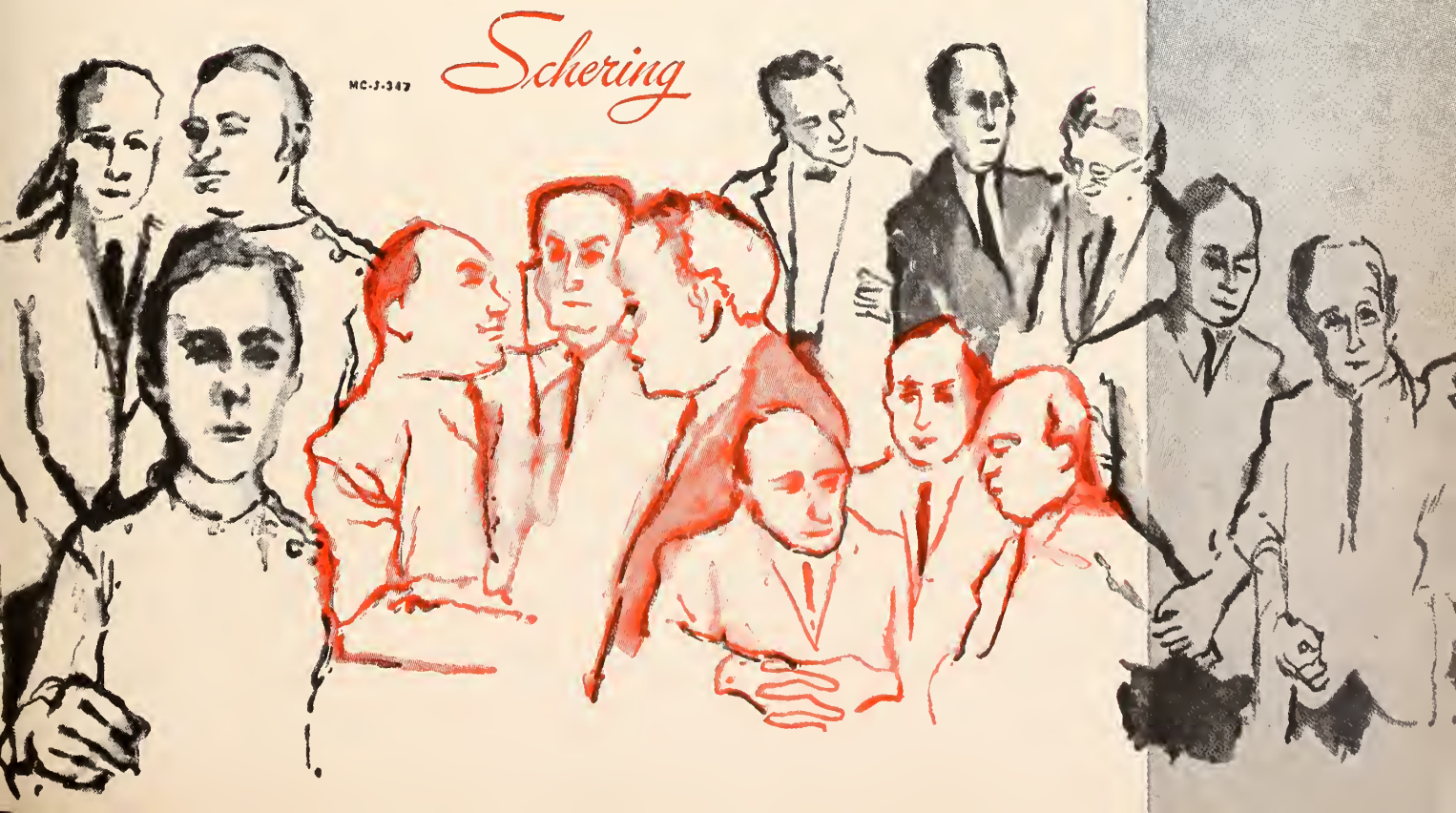

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

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Some Indications for the Use of Chemotherapy in Neoplastic Disorders*

ROBERT J. ROHN, M.D.
WILLIAM H. BOND, M.D.
Indianapolis

IT IS AXIOMATIC that cancer can be cured only by complete surgical removal or total eradication accomplished by irradiation. Employing such measures, two of every six persons suffering from neoplastic disorders are currently being cured. It has been further estimated by the American Cancer Society that an additional person in this group of six individuals could be cured if help was sought, and offered, in time. The obvious corollary of the previous statements is the realization that three of six persons suffering from neoplastic disorders cannot be cured by those measures currently available to even the best informed physician. It becomes a matter of utmost importance, therefore, that maximum effort be given to research efforts designed to improve these figures.

One of the important facets of expanding research and clinical activity is the attempt to find an agent or agents which can selectively inhibit the growth of neoplastic cells while leaving normal cells undamaged. There would seem to be no theoretical reason to deny the possibility that such an agent could be found, and, in an effort to find such an agent, thousands of old and new chemical and hormonal substances having the ability to affect cellular growth and survival have been and are being subjected to chemical and physical analysis, tissue culture and experimental animal trial, and, where feasible and indicated, are being employed in the treatment of patients suffering from a variety of neoplastic disorders.

To date, none of these agents has been demonstrated to have cured any patient of cancer. All of them have undesirable side effects which necessitate continuous careful supervision of all patients receiving them. Many potent agents,

* This work was supported in part by the American Cancer Society Institutional Research Grant #INSTR-81B and in part by a grant from the Alexander and Margaret Stewart Trust Fund.

We are grateful to the Lederle Laboratories Division, American Cyanamid Company for Triethylene Melamine and Aminopterin, also Burroughs Wellcome and Company for Chlorambucil (Leukeran)® and 6-Mercaptopurine (Purinethol)® and CIBA Pharmaceutical Products, Inc. for their Colcemide®.

however, are now available for the patient with incurable cancer, that can, in a significant number of instances, cause sustained remissions, reduce periods of hospitalization, afford symptomatic subjective palliative relief and possibly as adjuncts to surgical and radiological extirpation increase the possibility of cure of certain types of cancer.

AGENTS PROVED USEFUL

While it is manifestly impossible, in a single article, to discuss completely all the chemotherapeutic agents under trial, it would seem pertinent to discuss in general terms those agents that have received extensive clinical trial and proved to be of significant palliative usefulness. It has been possible to employ many such chemotherapeutic agents in clinical trial against a variety of neoplastic disorders at Indiana University Medical Center. It is possible that the experience we have had in the use of these agents might be of some interest. In this presentation, no agent will be discussed in complete detail, we are rather attempting to indicate those areas where we have found such agents to be most useful, and where possible, the toxic side effects which have proved troublesome to us in our employment of such agents.

Historically, arsenic is probably the first of the chemotherapeutic agents employed in a variety of neoplastic disorders and, as late as 1932, Forkner[1] was advocating the use of this agent in the treatment of chronic leukemia. We have seen a rare patient with chronic myelocytic leukemia treated with this agent, but in view of the many objectionable side effects of this metal and in view of the wide variety of more effective agents available for use in this disease, there is very little justification for employing this drug today.

Benzol (benzene) has been similarly employed[2] but most objections to arsenic apply with even greater force to this agent.

Historically, the first of the modern day cytolytic agents to be given clinical trial were the nitrogen mustards. Krumbhaar and Krumbhaar[3] had noted that mustard gas (a vesicant toxic agent employed in World War I) caused leukopenia with aplasia of the bone marrow and dissolution of lymphoid tissue. Various analogs of mustard gas including the nitrogen mustards were synthesized in the years between World War I and World War II and many were tested as to their biological activity and chemical behavior. Goodman, Gilman, and Dougherty[4] tested the nitrogen mustards in mice with lymphosarcoma. They noted that there were marked regression of tumor tissue with doses which were tolerated by their hosts. Accordingly, they first treated a human patient suffering from a malignant lymphoma in 1942[5]. The results were sufficiently interesting that extensive cooperative trials with the nitrogen mustards were initiated by Goodman and associates[6], Jacobson and associates[7], and Rhoads[8].

Nitrogen mustard (HN_2) is marketed as Mechlorethamine® and Mustargen®. Many other nitrogen mustard analogs have been tested but the substances which have received the widest clinical trial and shown the greatest therapeutic benefit are Triethylene Melamine (TEM); Chlorambucil (Leukeran®), Triethylene phosphoramide (TEPA) and Triethylene thiophosphoramide (Thio-TEPA). These have all been clinically employed to a greater or lesser degree at the Indiana University Medical Center and since each has differing effects, modes of adminitsration and indications for use, it would seem most feasible to consider each separately.

NITROGEN MUSTARD (HN_2)

This is supplied as 10 mgm. of a dry powder sealed in an airtight ampule. The powder, when placed in solution with sterile distilled water, is quite unstable and should be used immediately after mixing for maximal effect. The total dosage given as an individual course is based on the real weight of the individual and it has been our custom in most patients with neoplastic disorders to anticipate giving a total dosage of 0.5 mgm. of HN_2/kg. of body weight. This is ordinarily administered in divided dosage over a period of three to five days according to individual tolerance of the patient.

It has been our custom to administer the HN_2 in the following fashion. We elect to start therapy at 3:30 P.M. to 4:00 P.M. A relatively vigorous dose of parenteral barbiturate (250-500 mgm. of sodium amytal for the average adult) is given at this time and an intravenous infusion of 500 cc. of normal saline is started in the antecubital fossa of the arm. Twenty to thirty minutes after starting the intravenous infusion, the HN_2 solution is prepared.

HN_2 powder is dissolved by injecting 10 cc. of sterile distilled water into the vial with a

sterile Luer-lok syringe and needles. The appropriate, desired amount of HN_2 is then withdrawn into the syringe and the remainder is discarded. At this time, the arm is checked to assure the operator that the intravenous infusion is well located without evidence of tissue infiltration. Under no circumstance should HN_2 be injected unless there is absolute assurance that no HN_2 will leak out into the surrounding tissues. When this has been ascertained, the infusion is allowed to flow without check and the solution of HN_2 is injected by inserting the needle into the rubber connection attaching the infusion tubing to the intravenous needle and injecting the HN_2 rapidly but without haste into the connecting tubing. The remainder of the normal saline infusion is allowed to flow, thus assuring that local vesicant effects of the HN_2 upon the vein employed will be minimized or avoided. The patient is disturbed as little as possible over the next three to six hours and no food is offered unless the patient proves to be exceptionally hardy, and insists on eating at the regular dinner hour.

It is customary in those patients who have not been treated previously with HN_2 to give 0.1 mgm. of HN_2/kg. of body weight on the first day of therapy. If the medication is well tolerated, two additional doses of 0.2 mgm. of HN_2/kg. of body weight on each of the next two succeeding days are given to complete the total course of 0.5 mgm. of HN_2/kg. of body weight.

In the patient who is moderately upset by HN_2, it has been our custom not to exceed 0.1 mgm. of HN_2/kg. of body weight per day. At times, it may even be necessary to allow a day or two to elapse without therapy when the patient is seriously distressed by this medication.

It is our custom not to repeat a full course of HN_2 (0.4-0.5 mgm. HN_2/kg. of body weight) until at least four weeks time has elapsed since the last preceding course of HN_2 administration, and we much prefer to allow at least two or three months to intervene between succeeding courses of HN_2. It frequently occurs, of course, that the beneficial effects of a course of HN_2 will exceed a three month period in which case no additional HN_2 need be given.

The most frequent undesirable toxic side effect of HN_2 is the nausea and vomiting induced by the administration of this agent. As has been outlined above, adequate sedation with barbiturates and determined efforts by hospital personnel to keep the patient undisturbed will minimize this complaint. In some patients, these simple measures will prove inadequate. When some steroid hormones are given concomitantly with the HN_2, they are usually quite effective in eradicating nausea and vomiting. When we contemplate the administration of HN_2 to a patient who we know is excessively nauseated by this agent, we usually administer Prednisone in 20 mgm. per day dosage or Cortisone in 100 mgm. per day dosage 48 hours before we start the HN_2. The chosen steroid should be given throughout the course of the HN_2 and we have made it a habit to taper-off the steroid gradually over a five to seven day period after termniating the course of the HN_2.

It has been our experience that the usual antiemitic agents are not strikingly effective in controlling severe nausea and vomiting when they are caused by HN_2.

A more serious complication of HN_2 therapy is suppression of normal bone marrow activity. Only rare individuals will fail to show some depression of blood values after a course of HN_2. Fortunately, if succeeding courses of cytolytic therapy are not given in too rapid succession, this complication usually does not present too serious a problem. It is customary to note a fall in granulocytes starting within three to five days after initiation of HN_2 treatment. When the leukocyte count is less than 2,000/cu.mm. we have customarily prophylactically administered an oral, broad-spectrum antibiotic until more normal leukocyte levels are achieved. In the face of thrombocytopenia, we have found steroidal hormonal therapy most effective in the prevention of purpura and other bleeding complications. Anemia resulting from HN_2 treatment is seldom of sufficient severity to warrant blood transfusion. Report of ulceration of the gastrointestinal tract following exposure to nitrogen mustards has been made[3] but such an unfortunate experience has occurred only once in the hundreds of administered doses of HN_2 that we have given. This was an esophogeal perforation which was associated with peptic ulceration of the esophagus which had resulted from a protracted period of vomiting which had preceded the administration of HN_2.

HN_2 is a vesicant, and potentially capable of damaging mucous membranes or subcutaneous tissues when improperly administered or handled.

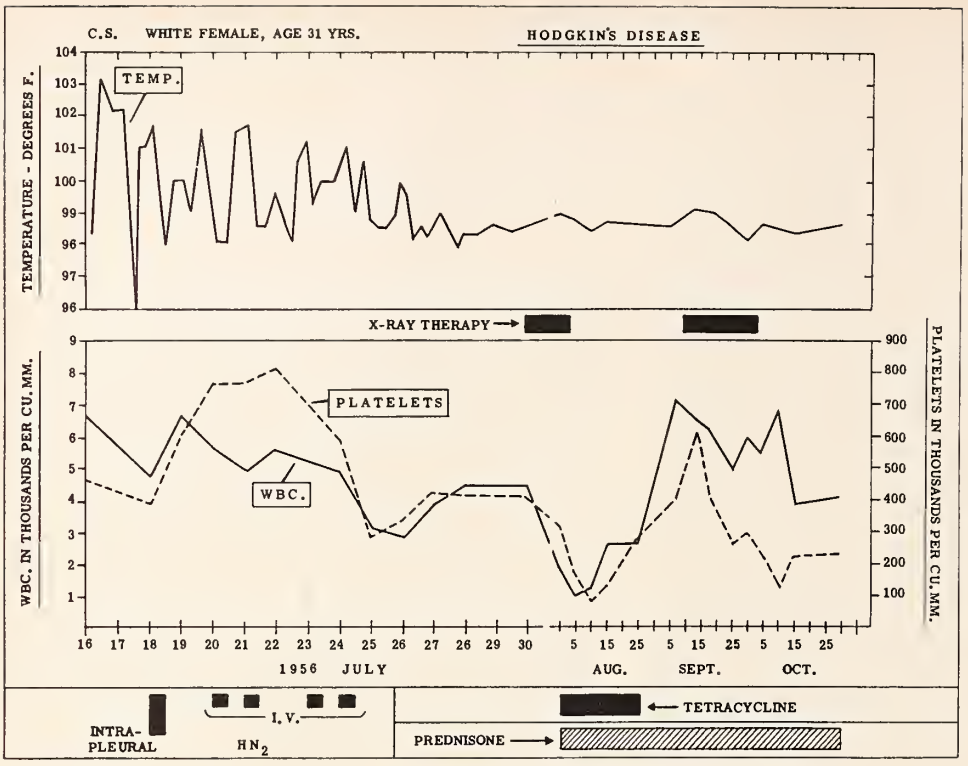

Figure 1.
C. S. Advanced case of Hodgkin's disease with disseminated disease and persistent pleural effusion. Fever and effusion controlled effectively by combined therapy with nitrogen mustard, x-ray therapy and steroids.

By insisting on scrupulous adherence to the above outlined technique of administration, however, we, to date, have had no local tissue damage.

HN_2 should not be given to a pregnant female since this agent, if it does not cause abortion, is potentially capable of deforming the foetus.

HN_2 has for us proved most useful in the following neoplastic disorders:

1. **Hodgkin's Disease**—Widely disseminated Hodgkin's disease or localized Hodgkin's disease of the liver or central nervous system are most effectively treated by an initial course of HN_2. Not infrequently where large quantities of Hodgkin's tissue are present or when the disease is manifest in the central nervous system combined treatment with HN_2 and x-ray therapy will prove most effective. Since such dissemination is frequently a late manifestation of Hodgkin's disease, pancytopenia may necessitate the combined use of steroids and HN_2 so that severe or hazardous pancytopenia will not result. (See Figure 1.)

2. **Neoplastic Pleural and Peritoneal Metastatic Implants** — When cancerous or lymphomatous implants establish themselves on serous surfaces, troublesome collections of fluid often embarrass the patient. In such circumstances, the local instillation of HN_2 into the collected fluid often proves quite effective in controlling further fluid collection[9]. In such a circumstance, a small amount of the aspirated fluid is employed to mix the nitrogen mustard. A total dose of 0.4 mgm./kg. of body weight is calculated and the entire dosage is injected in a single injection into the affected intracavitary space. We have found this to be most effective when the causative disease is one of the lymphoma group (See Figure 1) but we have benefited some patients in whom this represents a complication of metastatic carcinoma.

3. **Bronchogenic Carcinoma**—In certain instances of patients suffering from inoperable bronchogenic carcinoma, distressing symptoms caused by diffuse pulmonary invasion or superior vena caval obstruction may be temporarily alleviated by use of HN_2[10], particularly when it can be combined with local irradiation. In treating such patients, we have given HN_2 in divided doses employing complete course dosage of 0.4 to 0.5 mgm/kg. of body weight using the same technique as that previously described in treating disseminated Hodgkin's disease. We are quite interested in injecting HN_2 directly into the blood vessels[11] supplying an inoperable bronchogenic carcinoma, but we have not, to date, encountered a case suitable for such therapy.

4. **Miscellaneous**—We have employed HN_2 in a variety of disorders including polycythemia rubra vera, giant follicular lymphoma, chronic and acute leukemia, but except for rare instances,

more effective, less toxic measures are usually available. We have attempted to treat a variety of advanced carcinomas of the cervix, breast, ovary, rectum, stomach and even malignant melanomas with this agent but we have not been impressed with its effectiveness in such problems. Of considerable interest is the program employing HN_2 either locally in the operative site or systemically by intravenous injection in all patients undergoing definitive attempted curative surgery of neoplastic growths. Dr. Cole[12], who heads this project, is attempting to control any possible metastatic cells that might be broken off the tumor mass in the process of operative removal.

TRIETHYLENE-MELAMINE (TEM)

This agent is one of the nitrogen mustards which may be given orally or parenterally. It usually is taken by mouth in the form of a 5 mgm. tablet. Clinical evidence seems to suggest that TEM is somewhat unstable and pills from two lots of the drug may have slightly differing levels of therapeutic and toxic effects. This variation may be minimized by keeping this agent refrigerated until it is ready to be used.

TEM has the same therapeutic and toxic effects manifested by HN_2 but both effects are much milder in the case of TEM. We have found this to be a very useful agent in a number of conditions because it is relatively cheap, easily administered and when appropriate precautions are observed, it may be given on an out-patient basis.

TEM will be inactivated by food, so it is customarily administered two hours before the first meal of the day. The dose will vary considerably according to the condition in which it is used so it will be considered in relationship to the specific disease to be treated. The diseases in which TEM has proved most effective for us are as follows[13]:

1. **Chronic Lymphocytic Leukemia**—TEM has proved to be a useful agent in the treatment of this disorder. We have used it as the sole means of therapy in those patients who do not demonstrate massive lymphadenopathy or splenomegaly and we have used it to prolong remission periods between x-ray therapy in others. Patients with this disorder vary widely in their cellular response to this agent, so that in a case not previously treated with this medication we proceed with considerable caution. A single dose of 5 mgm. is given and the patient is observed for a two week interval. If the total white count has dropped below 20,000, no further medication need be given. The usual patient carrying a 50,000 to 150,000 leukocyte count will require two tablets to achieve satisfactory remission. Ordinarily, such remission will persist for three to six months but we have cared for one patient who required 5 mgm. each week for three years to sustain his remission. Occasionally, marked displacement of marrow by leukemic cells will be associated with peripheral leukopenic counts. In these instances, 10 mgm. of TEM may prove to be literally life saving in freeing the marrow.

2. **Chronic Myelocytic Leukemia** — Here much larger doses will need to be employed to maintain control of the leukemic process. No absolute dosage schedules can be described to satisfactorily control every case and the clinician must be guided by the hematological response. 5 mgm. daily should be given until the leukocyte count has fallen below 20,000 white blood cells/cu. mm. or sharply falling values over a three day period presage a precipitous fall in total leukocytes. Ordinarily, the previously untreated patient will require daily administration of 5 mgm. of TEM for 10 to 21 days before remission is observed. Usually 5 mgm. of TEM every one to four weeks will be required to maintain hematological remission. This dosage will of necessity be modified when treating children with this disorder (Figure 2).

3. **Hodgkin's Disease**—In our experience, TEM has proved less satisfactory than x-ray or HN_2 in controlling Hodgkin's disease. It is sometimes effective in prolonging periods between courses of x-ray or HN_2 therapy. 15 mgm. of TEM is given in three divided doses on consecutive days, and this course is ordinarily not repeated until 30 to 90 days have elapsed.

4. **Polycythemia Rubra Vera**—When administering TEM in polycythemia rubra vera, the effectiveness of TEM cannot be predicated absolutely on previous response to radiation therapy. Some patients who respond gratifyingly to P32 are seemingly unaffected by intensive therapy with TEM, although similar success with TEM in the face of P32 failure may be encountered. In these patients, 15 mgm. of TEM will usually suffice to effect hematological remis-

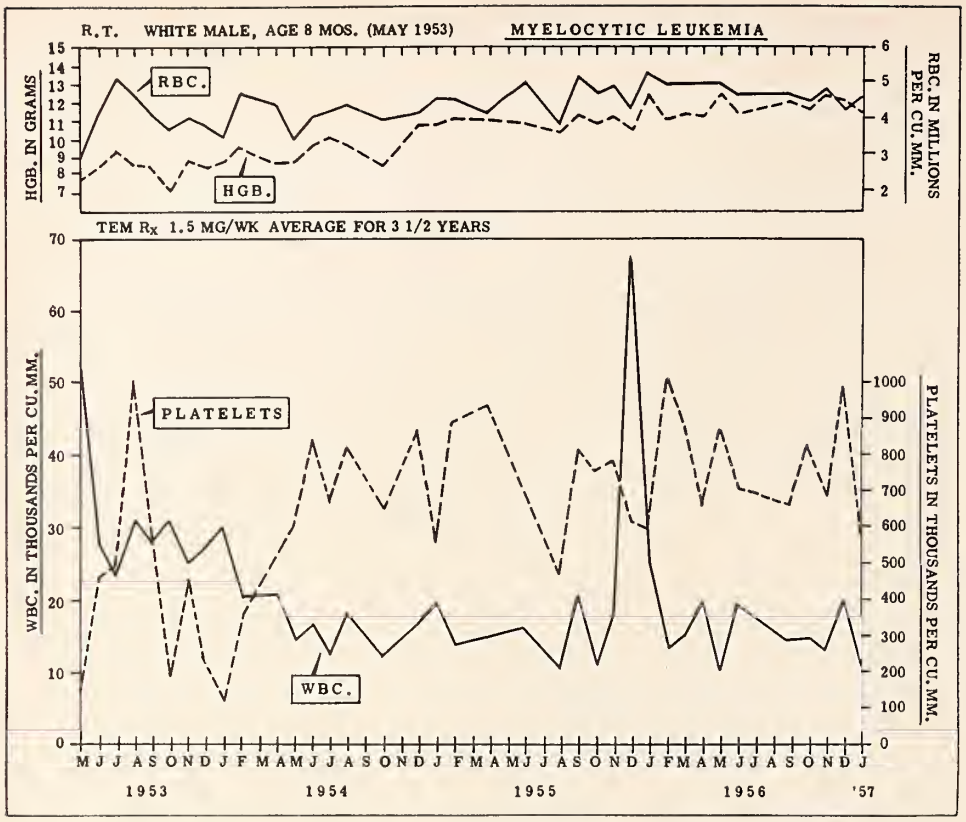

Figure 2.
Chronic myelocytic leukemia in extremely young child controlled by TEM.

sion and such remissions may persist for 6 to 18 months.

5. **Miscellaneous** — Disseminated follicular lymphoblastoma, chronic leukemia cutis, and mycosis fungoides may be favorably affected by 5 to 10 mgm. TEM. Acute monocytic leukemia may be partially controlled with very small doses of TEM (2.5 mgm.) with control of infiltrates and reestablishment of favorable platelet values. We have had occasional patients with far advanced metastatic carcinomatosis of the breast who have demonstrated striking remissions of two to twelve months following the administration of 10-20 mgm. of TEM.

CHLORAMBUCIL (LEUKERAN®)

This agent is the most recently offered of the nitrogen mustard derivatives.[14] It has a relatively low order of toxicity when compared with HN_2 or TEM but it, unfortunately, has a rather low order of therapeutic effectiveness when used for those ailments readily controlled by its more potent chemical relatives. We have had only limited experience with this agent, employing it in the treatment of Hodgkin's disease, mycosis fungoides, acute monocytic, acute myelocytic and acute lymphocytic leukemias, and in only a rare person with a variety of advanced cancers.

We have found it most useful in mild disseminated Hodgkin's disease, and in advanced disseminated Hodgkin's with iatrogenic marrow hypoplasia. We are currently much interested in using it as combined therapy with anti-metabolite agents where early observations would suggest synergistic effectiveness by such combined therapy (Figure 3). No fixed dosage schedule can be employed in every patient, but in most instances a dose of 0.3 mgm./kg. of body weight given daily for 21 days will usually be most effective with only occasional episodes of transitory marrow hypoplasia. We have encountered only one patient in whom any noticeable gastrointestinal complaints have been associated with use of this agent.

TRIETHYLENEPHOSPHORAMIDE (TEPA) AND TRIETHYLENETHIOPHOSPHORAMIDE (THIO-TEPA)

These agents which are related to the nitrogen mustards, have been used in the treatment of malignant melanoma[15] and most recently have been suggested as the chemical agents of choice in the treatment of advanced metastatic breast carcinoma.[16]

We have had a somewhat limited experience with these drugs and have found them somewhat less effective than other cytolytic agents.

Anti-metabolite agents have demonstrated moderately selective cytotoxic effect against various neoplastic cells and a considerable number

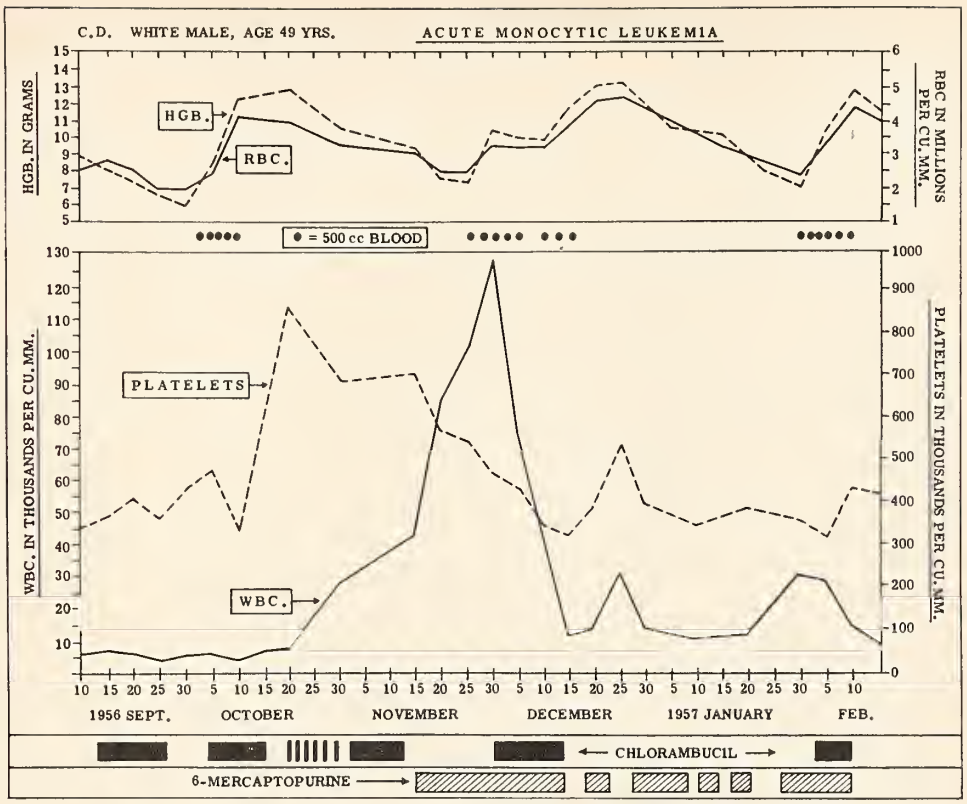

Figure 3.
C. D. This patient with acute monocytic leukemia illustrates the combined use of Chlorambucil and 6-Mercaptopurine in controlling the disease.

of these agents have been tested by laboratory, animal and clinical therapeutic trial. A great many of these agents have been subjected to clinical trial. The agents most extensively tested include Aminopterin, Purinethol®, and Azaserine. These agents mimic essential nutritional substances required to support cellular metabolism and, by blocking the uptake or utilization of these essential metabolites, cause cell death. Since neoplastic cells have a more rapid energy exchange than normal cells, selectively greater destruction, and inhibition of neoplastic than normal tissues can be anticipated when both cell types are deprived of necessary metabolites. When this occurs, remissions may be induced in certain neoplastic disorders.

AMINOPTERIN

This agent is a folic acid antagonist which blocks the conversion of folic to folinic acid[17]. It is supplied as a 0.5 mgm. tablet and is potentially a very toxic agent. It inhibits hematopoiesis, and may cause widespread ulceration of mucous membranes and skin. Alopecia and suppression of menstruation are additional troublesome side effects occasionally encountered when this drug is used.

No definitive dosage schedule can be offered and the drug usually must be pushed to mild toxic levels before remission can be anticipated. We commonly utilize a daily dosage of 0.5 mgm. until the earliest evidence of toxicity is manifested. This usually is a fine hemorrhagic ulcerative stomatitis of the lips, tongue or gums. If remission is to be obtained, it usually will become evident 5 to 14 days after the first evidence of toxicity has been displayed. When toxic manifestations seem to threaten life, steroidal therapy and/or folinic acid may need to be employed to suppress these threatening toxic manifestations. We have used Aminopterin in treating the following conditions:

1. **Acute Lymphocytic Leukemia**—We have treated more than a hundred patients with this drug, and currently we have restricted it almost 100% to the treatment of acute lymphocytic leukemia of infants and children (Figure 4). We have been successful in achieving complete sustained remission in several adults with this drug but it is so damaging to mucous membranes of the gastrointestinal tract of most adults that therapeutic levels can only rarely be achieved. We have observed a maximum survival of 23 months in a child with acute leukemia treated with this and other agents.

2. **Acute Monocytic Leukemia**—An occasional child with acute monocytic leukemia has demonstrated hematological remission after this

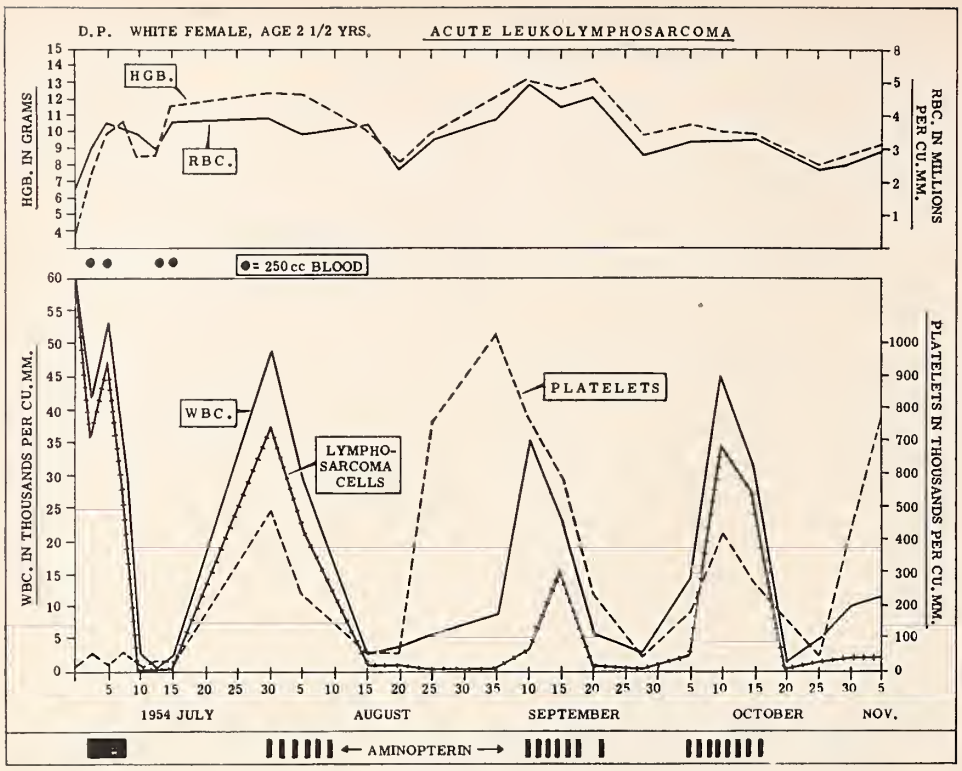

Figure 4.
D. P. Aminopterin in the treatment of acute lymphocytic leukemia (leukolymphosarcoma) showing repeated good hematological remissions.

drug has been employed but ordinarily this is not the therapy of choice in this disease.

3. **Miscellaneous**—We have treated some patients with acute myelocytic leukemia, neuroblastoma, and medulloblastoma with this agent with indifferent results.

6-MERCAPTOPURINE (PURINETHOL®)

This is a potent purine blocking agent whose principal toxic effect is the inhibition of hematopoiesis[18]. Damage to other tissues is seldom encountered, although an occasional patient may complain of gastrointestinal distress or demonstrate ulcerative stomatitis or gastroenteritis following prolonged therapy with this agent. It has been our experience that when marrow aplasia occurs following overdosage with Purinethol®, it is prolonged and unaffected by any agent we have had the opportunity to employ. Because it is so generally innocuous as far as clinical mani-

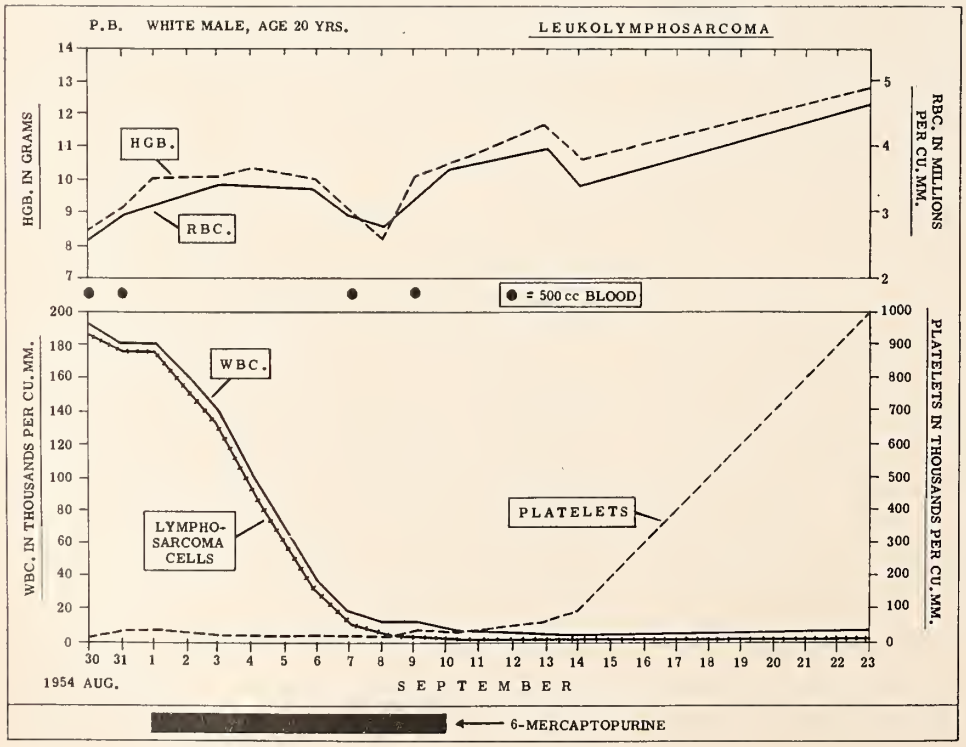

Figure 5.
P. B. Adult with acute lymphocytic leukemia (leukolymphosarcoma) demonstrating hematological remission following therapy with 6-Mercaptopurine.

festations are concerned, and since leukocyte counts offer the only reliable easy measure of effect, we prefer to use this drug only in those patients with elevations of the leukocyte count. When we have to treat patients demonstrating leukopenia, it has been our custom to give intermittent doses five days at a time, allowing two to three days to elapse between courses and resorting liberally to bone marrow biopsy to measure hematopoetic activity. We employ a daily dose of 2.5 mgm./kg. of body weight. We have employed Purinethol® in the following conditions:

1. **Acute Lymphocytic Leukemia**—Purinethol® may be employed to advantage in this disease, although we customarily start therapy with Aminopterin in infants and children withholding Purinethol® until refractoriness to Aminopterin is demonstrated. This is not the case in adults where the lack of gastrointestinal complications makes this a useful agent (Figure 5).

2. **Acute Monocytic Leukemia**—Currently, Purinethol® is our drug of choice in controlling the manifestations of this disease (Figure 6). We rarely achieve complete hematological remission but partial hematological remission with good clinical remission is seen in about one-half of our patients so treated. We are currently employing concomitant therapy with Chlorambucil with some suggestion that these two agents may act synergistically (Figure 3).

3. **Acute Myelocytic Leukemia**—We have employed Purinethol® in the treatment of several patients with acute myelocytic leukemia and many patients with myeloblastic exacerbation of chronic myelocytic leukemia. These disorders in the past have been uniformly and quickly fatal. Purinethol® is the first agent we have employed with which we have ever been able to salvage any of these patients. The drug must be pushed vary hard to the point of toxicity. By resorting to such measures, we have observed remissions in excess of six months in four patients with these disorders.

4. **Reticulum Cell Sarcoma**—We have treated several patients with widely disseminated leukemic reticulo-endothelioses and reticulum cell sarcoma (Figure 7). When used in conjunction with radiation therapy, remissions of six months to three years have been observed.

AZASERINE

This agent has been employed in the acute lymphocytic leukemias of childhood but we have had no experience in the use of this agent[19].

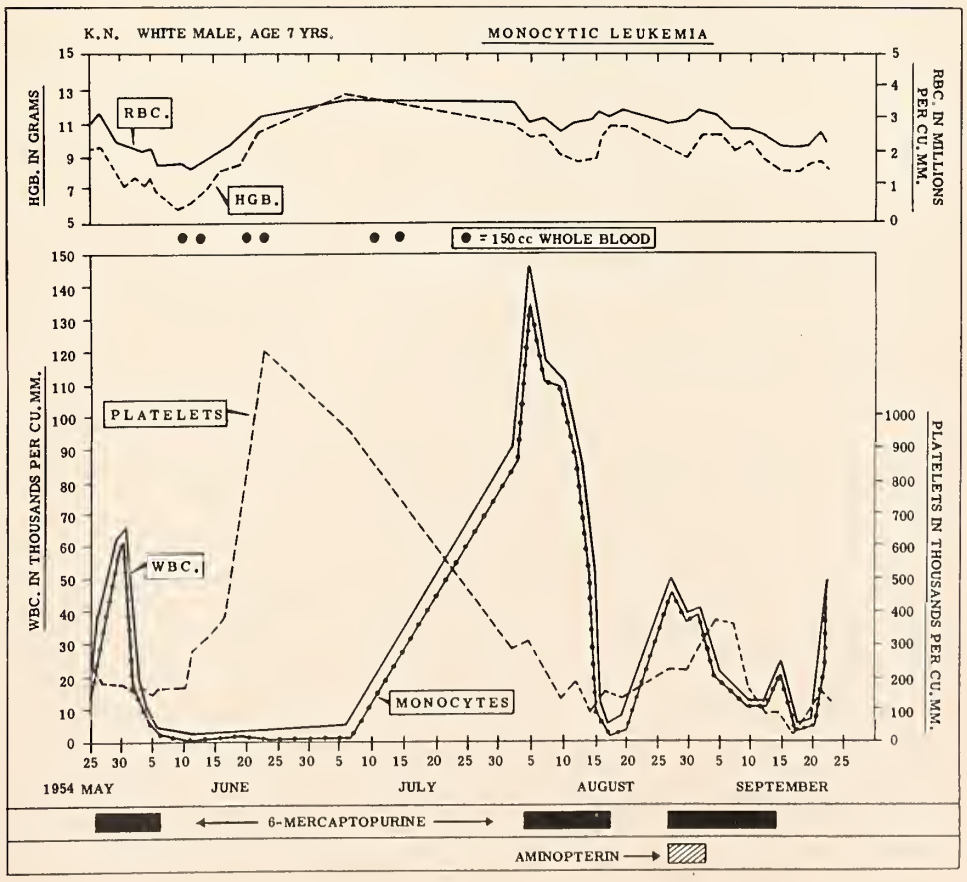

Figure 6.
Initial partial hematological remission in acute monocytic leukemia with 6-Mercaptopurine. Later refractoriness to both 6-Mercaptopurine and Aminopterin.

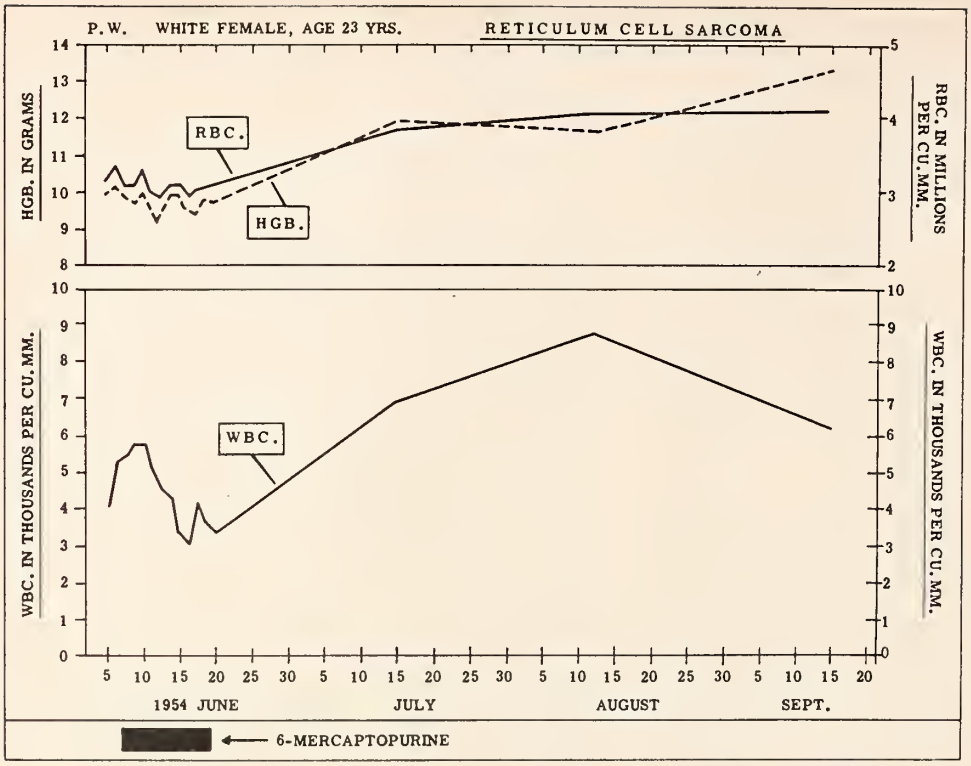

Figure 7.
P.W. Prolonged survival in adult female with disseminated reticulum cell sarcoma treated with 6-Mercaptopurine.

STEROIDAL HORMONES

ACTH, Cortisone, Prednisone and Prednisilone have been employed in the treatment of many neoplastic disorders with varying effects[20]. The toxic effects and dosage vary from one agent to another but in general, we have noted the following in using these agents in the treatment of neoplastic disorders. We favor adreno-cortical hormones to adrenocorticotrophic hormones because of their ease of administration, avoidance of injection therapy and flexibility of sustained administration. In general, it has been our experience that larger doses must be employed to obtain remission than when these agents are employed in the treatment of inflammatory joint and skin disease. In general, we tend to use more Prednisone than any other of these agents because of the greater freedom from salt restriction. It is our impression that we see an increased incidence of gastrointestinal hemorrhagic complications with prednisone than with cortisone, but accept this as a necessary evil which is outweighed by the many advantages associated with the use of this agent. We find steroidal hormones most useful in the following disorders.

1. **Hodgkin's Disease**—Steroidal hormones are quite useful in the long term management of the patient with Hodgkin's disease. These agents not only suppress Hodgkin's disease activity and much of the fever and pruritus associated with Hodgkin's disease but by sustaining a hypoplastic marrow, they allow many courses of systemic therapy to be given that otherwise could not be given because of possible fatal marrow aplasia. When employed in this fashion, the steroid should be started 48 hours before the initiation of systemic cytolytic therapy and should be given for two to four days after initiation and completion of HN_2 or TEM therapy.

2. **Acute Lymphocytic Leukemia**—Steroidal therapy will effect hematological remission in infants and children with acute lymphocytic leukemia. The most serious complication encountered when such medication is used over a prolonged period is severe osteoporosis with collapse fractures of the vertebrae. Since this presents such a troublesome complication, we tend to reserve the use of steroidal therapy in these children until they have become refractory to all other agents.

3. **Carcinoma of Breast and Prostate**—Any detailed discussion of hormonal therapy should be left to the urologist, the endocrinologist, the surgeon, and neurosurgeon. To be complete, however, brief mention should be made of the remarkable remissions that may occur when selected patients with advanced cancer of the breast and prostate are treated with adrenocortical female and male sex hormones, and extir-

pative removal of the testicles, ovaries, adrenal cortices and pituitary glands. These agents and procedures may offer considerable help to those patients who cannot be controlled by more commonly employed procedures.

MISCELLANEOUS AGENTS

Myeleran has been employed in the treatment of some leukemias and some investigators feel that this is the agent of choice in the treatment of chronic myelocytic leukemia[21]. We have, unfortunately, not had the opportunity to make any extensive clinical trial with this agent.

ETHYL CARBAMATE (URETHANE)

This drug has been employed in the treatment of the chronic leukemias and multiple myeloma[22]. It may suppress hematopoiesis and its use is frequently associated with nausea and vomiting. It has been postulated that the nausea attendant on the use of this drug may be minimized by giving it rectally or by intravenous injection. We have not observed any amelioration of its emetic effect, however, when employing such alternate routes of administration. If the drug is administered in enteric coated tablets and given immediately after meals, very gradually increasing the daily dosage from 0.3 to 4.5 grams most patients can be kept on effective therapeutic levels for 30 to 90 days if severe inhibition of marrow does not mandate stopping the drug prior to this time. Because of the high incidence of nausea and vomiting, we tend to restrict use of this drug to the treatment of multiple myeloma. Anti-emetic drugs in some instances decrease the incidence and/or severity of nausea. Steroid hormones also tend to decrease the emetic effects of Urethane and, because of their weak anti-myeloma cell action, are often indicated as adjunctive therapy.

DEMECOLCIN (COLCEMIDE)

This agent is widely employed on the European continent in the treatment of various chronic leukemias and lymphomas[23]. We have had the opportunity to have tried this agent in a small number of patients but because of its weak cytolytic effect, it would seem to be inferior to many other agents currently available.

CONCLUSIONS

It should not be assumed that this is intended to be a complete discussion of all chemotherapeutic agents used in the treatment of neoplastic disorders, nor do we intend to imply that the above agents should be used to the exclusion of other agents in the disorders discussed.

We still feel that the treatment of choice in neoplastic disease is complete extirpation of the malignant growth whether it be accomplished by surgical removal or eradicated by application of radiant energy whether such emanates from a high voltage radiation therapy machine, a cobalt bomb, a linear accelerator, or the local application of radium or radio-active cobalt in the tumor.

We still must rely heavily on the radiation therapist to assist us in our care of these patients and in many instances the major load of treatment must rest on his shoulders.

As familiarity with the various agents that can be employed in the palliative care of patients with incurable neoplastic disorders grows there will be an increasing reliance on multiple combinations of various agents as differing situations alter the circumstances. By the increased awareness of agents that can be used and the knowledge of the situations in which one agent is superior to another agent, a decrease in cost, an increased number of effective days, and greater patient satisfaction and comfort can be expected to follow in these patients requiring long term palliation of neoplastic disease.

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Abstract:

MOLES BENIGN OR POTENTIALLY MALIGNANT

Commack, K. V.: J. Michigan State Medical Society 55:1353 (Nov. 1956).

Admittedly the removal of a nevi can be important cancer prophylaxis, but the physician hesitates to remove every one of the very numerous moles which develop on the skin of some patients. This author presents a few tenets based on gross and microscopic characteristics which are helpful in determining the malignant potentialities of nevi.

Melanomas are classified into five main groups:

1. The intradermal nevus is benign and is never found on the extremities or the genitalia. Microscopically these lesions have intact epidermis and melanoblasts are found only within the dermis.

2. The junctional nevus is flat, hairless and may be any shade of pigmentation from tan to black. It is usually found on the extremities, genitalia or head and neck. Microscopically melanoblasts and pigment are found in the lower epidermis. It is believed that nearly all melanocarcinomas arise from junctional nevi.

3. Compound nevus represents a combination of the two above types and is more commonly found before puberty.

4. Juvenile nevi are found in prepubertal patients. Melanocarcinoma is very rare before puberty. It is to be remembered that the microscopic appearance of these benign lesions may simulate malignancy.

5. Blue nevi, usually located on the buttocks and the dorsum of the hands and feet are rarely malignant. Well differentiated cells from these lesions are occasionally found in adjacent lymph nodes with no further metastasis.

There appears to be some endocrine influence on the growth of nevi and melanocarcinoma. It has been reported that ACTH therapy has initiated new junctional nevi in adults. Junctional nevi, have been reported, to arise in different parts of the body concurrently, and pregnancy accelerates the growth of melanocarcinoma.

It is believed that trauma has no relation to the development of melanocarcinoma. Cold knife excision with removal of an adequate border of skin, is the proper management of potentially malignant nevi.

David A. Bickel, M. D., South Bend.

Carcinoma of the Prostate Presenting as a Hemorrhagic Disorder

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WILLIAM C. CALDWELL, M.D.
ROBERT R. ACRE, M.D.

Evansville

DURING THE PAST FEW YEARS there has been considerable interest in hemorrhagic states which are principally due to either a deficiency of fibrinogen in the blood or the lysis of formed fibrin.[1] A deficiency of fibrinogen in the blood may occur very rarely as a congenital defect, but more frequently it is a complication of various disease states. In the course of certain neoplastic diseases a hemorrhagic diathesis due to fibrinogen dysfunction may occur. Probably the most common type of neoplasm to cause such a hemorrhagic disorder is metastatic carcinoma of the prostate.[2] Usually this hemorrhagic diathesis occurs in the terminal phase of the disease. Recently we had occasion to observe a case of metastatic carcinoma of the prostate in which the initial symptoms were of a hemorrhagic disorder. This case is reported as follows.

REPORT OF CASE

On January 6, 1956, a 58 year old white male executive was hospitalized for diagnosis of purpura and anemia. He had enjoyed robust health until one year previously. During the past year he had noted slightly increased fatigue, which he had attributed to increased work load. Two months before admission, following slight trauma, he developed a huge ecchymosis of the left shoulder and chest wall. Subsequently other ecchymoses appeared on the trunk and limbs after insignificant trauma. There were several severe epistaxes. He lost about 15 pounds of weight. Only in retrospect did he remember slight hesitancy of urination.

Physical examination disclosed the following findings. Blood pressure and vital signs were normal. He had marked pallor and appeared severely, chronically ill. Over the trunk and limbs were many ecchymoses varying from 2 to 15 centimeters in diameter. Many of these seemed to have an underlying hematoma in the subcutaneous tissue. Only a few petechiae were seen on the lower legs and none were seen on the mucous membranes. There was no icterus. The bones did not seem tender. There was clotted blood in the right nostril. There was a two centimeter, firm mass in the left inguinal lymph chain which seemed firmly attached to the underlying tissues. No other lymph node enlargement was detected. The lungs were clear and the heart appeared normal. There were no palpable abdominal organs or masses. There was a right inguinal hernia. The genitalia were normal. The prostate gland was enlarged, very irregular, hard and fixed. The right knee jerk could not be obtained.

The urine was normal. The hemoglobin was 8.4 grams. The white blood cell count was 9,900. Blood smear disclosed a marked deficiency of platelets. The red blood cells showed marked polychromasia and basophilic stippling with moderate poikilocytosis. There were 4% myelocytes and 30 nucleated red blood cells per 100 white blood cells.

Application of a blood pressure cuff at 90 mm. mercury for five minutes produced only a few petechiae on the lower arm. The ear lobe bleeding time was five minutes. The clotting time (Lee-White) was 25 minutes. Clot retraction was negligible and the clots could be easily fragmented. The prothrombin time was 68% of normal. Fibrinogen index (Fibrinodex Ortho method) showed initial clot formation at 10 seconds which was at the upper limit of normal. Clots from the prothrombin time and fibrinogen index determinations were observed to be tiny

and when incubated at 37° C would disappear within six hours.

The acid phosphatase was 18.0 Bodansky units and the alkaline phosphatase was 10.5 Bodansky units. X-rays of the pelvis, lumbar spine and chest showed extensive osteolytic and osteoblastic metastases.

The patient was given blood transfusions and on January 9, 1956 started on diethylstilbestrol at a dosage of 20 milligrams daily. Three days later spontaneous purpura ceased and five days after starting diethylstilbestrol hematomas and ecchymoses no longer formed at needle puncture sites. Seven days after starting diethylstilbestrol the blood smear still showed marked reduction of platelets. Lee-White clotting time was 19 minutes. The prothrombin time was 100%. Two weeks after starting diethylstilbestrol the hemoglobin was 10.3 grams. The platelets on blood smear had increased to the low normal range, the morphologic abnormalities of the red blood cells were greatly reduced and the proportion of normoblasts had fallen to seven nucleated red blood cells per 100 white blood cells. The tourniquet test was negative. The bleeding time was four minutes. Lee-White clotting time was 22 minutes and the clot retraction was moderately good. The prothrombin time was 100%. Fibrinogen assay showed initial clot formation at five seconds. Plasma clots still seemed smaller than normal but after unsterile incubation at 37°C for 24 hours the remaining clots were 50% of the original size. Sterile incubation of whole blood at 37°C for 24 hours showed a moderate size clot which could be easily fragmented but not dissolved.

It was decided to proceed with orchidectomy. Hydrocortisone, 100 milligrams daily, was given for three days preoperatively and tapered over six days postoperatively. The patient was transfused with 500 cc. whole fresh citrated blood the day before operation and again the morning of operation. At the time of orchidectomy on January 23, 1956, only a normal amount of bleeding was encountered but 48 hours later a confluent ecchymosis of the scrotum, penis and perineal area had developed. There was a small hematoma in the scrotal sac. The ecchymosis slowly resolved but the hematoma was persistent at the time of discharge. Postoperatively the acid phosphatase was 2.0 and the alkaline phosphatase was 18.2.

One month postoperatively the patient was feeling very well. There had been no further hemorrhagic phenomena. The prostate gland had greatly shrunken in size and the inguinal node had disappeared. There was a persistent fluctuance in the scrotal sac. The blood hematocrit was 36%. The white blood cell count was 9,100. The platelets appeared normal on blood smear. The red blood cells were normal in appearance. The white cell differential was normal and there were no myelocytes or normoblasts after thorough search of a blood smear.

The clotting time was 16 minutes. Sterile whole blood clots incubated at 37° for 24 hours showed moderate retraction but there were many loose red blood cells at the bottom of the tube. These clots were small but firm.

The patient has been maintained on five milligrams diethylstilbestrol daily for over four months since orchidectomy. He still tires easily and has been able to work only part time. There has been no recurrence of hemorrhagic phenomena of any sort. The blood hematocrit has stabilized at about 36%. The platelets and white blood cells are normal on smear and there are no abnormal cells in the bood. The Lee-White clotting time has been 16 minutes. The blood clots have been of normal size and retraction.

DISCUSSION

From the material presented in this case it was our firm opinion that the greatest factor in causing the coagulation defect was the impairment of normal fibrinogen-fibrin activity. The patient also had thrombocytopenia, probably due to bone marrow metastasis with myelophthisic anemia. However, there are several reasons to regard the thrombocytopenia as only a secondary factor.

1. Despite the fact that the patient was having active purpura and epistaxes there were very few petechiae on the skin and mucous membranes and the tourniquet test was only suggestively positive.

2. Several bleeding times were determined from both ear lobes and from finger pads. In all instances the bleeding time was normal and in each instance for at least 15 minutes following the puncture there was no purpura. Twelve to 24 hours following stylet puncture there would be a large hematoma at the puncture site. This delayed type of hemorrhagic phenomena was typical of the patient's coagulation difficulty.

3. The clinical bleeding and laboratory tests

were observed to vary independently of the platelet count. Three days after starting estrogen therapy the hemorrhagic phenomena ceased, but the platelets were not observed to vary for another 10 days. After orchidectomy the platelets were found to be quantitatively and morphologically normal on the blood smear but test tube clots still appeared to be smaller than normal.

There was positive evidence of a fibrinogen-fibrin abnormality. Clots of the patient's blood produced by any method were tiny, could be easily fragmented and disappeared after several hours of incubation. We could definitely conclude that a deficiency of fibrinogen existed, although we were unable to quantitate such a deficiency. The dissolution of the clots also suggested the possibility of a fibrinolysin activity. Such activity has been found in extracts of normal and neoplastic prostatic tissue.[3, 7] Some authors have felt that the coagulation defect in carcinoma of the prostate is entirely due to a fibrinolysin and that the hypofibrinogenemia was a secondary phenomena.[3] Others have felt that the apparent fibrinolytic activity was only due to the fragmentation of a poor clot.[6] We are unable to comment on this point. It is of interest that in our case there was initially a significant prolongation of the prothrombin time as has been described by others. There was never any evidence of hepatic metastases or any other liver disease.

SUMMARY

1. A case of metastatic carcinoma of the prostate is presented in which the initial symptoms were hemorrhagic.
2. Investigation disclosed deficiencies of both platelets and fibrinogen. Clinical course and laboratory findings indicated that the fibrinogen-fibrin abnormality was the main cause of the bleeding.
3. Treatment of the carcinoma produced a significant amelioration of the hemorrhagic state as principally manifest by a return toward normal of the fibrinogen content of the blood.

ADDENDUM

In December 1956 the patient was feeling well but on a routine examination was found to have a whole blood clotting time of 28 minutes. The hemoglobin, WBC and platelets were normal. In January 1957 weakness and malaise returned. Purpuric spots developed over the trunk and extremities.

Physical examination at this time disclosed tenderness over the thoracic and lumbar spine. There was moderate gynecomastia. The liver edge was felt two centimeters below the right costal margin. The prostate gland was normal size but there was a stony nodule one centimeter in diameter. The hemoglobin was 10 grams. There were nucleated red blood cells and myelocytes in the blood smear. Platelets were reduced on the smear. The bilirubin and alkaline phosphatase were normal. The acid phosphatase was 36 Bodansky units. The prothrombin time was 30%. The Lee-White clotting time showed no complete clot at the end of one hour. Filter paper electrophoresis of plasma showed a marked decrease in the fibrinogen spot.

On February 1, 1957 the dose of diethylstilbestrol was increased to 25 milligrams daily. Hydrocortisone, 60 milligrams daily, was given. On bed rest the cutaneous purpura seemed to abate. Ten days after starting hydrocortisone the whole bloodclotting time was 22 minutes and the acid phosphatase was 16 Bodansky units. Suddenly on February 25, 1957 the patient developed symptoms and signs of severe intracranial bleeding and died the same day. Unfortunately, autopsy permission was not obtained.

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Clinico-Pathological Conference: The Ninth Annual Postgraduate Symposium on Malignancy

*Case I: 50 year old man with convulsions involving the left arm.**

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THE MAJORITY of intracranial neoplasms show no direct clinical evidence of their presence. They must be suspected from the history of a disturbance in the function of the nervous system, a suspicion strengthened by discovery of abnormal signs in the neurological examination. Sometimes only the history gives evidence of disturbed physiology; a variety of tests must be used to confirm the diagnosis. The increasing scope and accuracy of diagnostic technics have made it possible to detect and treat intracranial neoplasms much earlier in their development. This improves the outlook for patients with intracranial neoplasms, as they can be treated before they become permanently disabled.

The case study reported here outlines the methods of detection and treatment of an intracranial neoplasm. The discussion of the case is particularly interesting because it was given by a group of distinguished men who have made contributions to knowledge of intracranial neoplasms. The group met at Indiana University Medical Center March 27 and 28, 1956 for the Ninth Annual Symposium on Malignancy sponsored by the Indiana Division of the American Cancer Society.

Participants:

Harry M. Zimmerman, M.D.—Chief, Laboratory Division, Montefiore Hospital, New York, N.Y.

Joe B. Penneybacker, M.D., F.R.C.S.—Director Neurological Surgery, Radcliffe Infirmary, Oxford, England.

Paul C. Bucy, M.D.—Chief of Division of Neurological Surgery, Chicago Wesley Memorial Hospital, Chicago, Illinois.

Douglas Buchanan, M.B., Ch.B.—Professor of Neurology and Pediatrics, University of Chicago.

Harold O. Peterson, M.D.—Clinical Professor of Radiology, University of Minnesota.

Reginald Bickford, M.B., Ch.B.—Consultant and Head of Laboratory of Electroencephalography and Neurophysiologist, Mayo Clinic, Rochester, Minnesota.

William T. Peyton, M.D.—Professor of Surgery and Director of Neurosurgery, University of Minnesota, Minneapolis, Minnesota.

Percival Bailey, M.D.—Distinguished Professor, Neurology and Neurosurgery, University of Illinois.

Edward B. Smith, M.D.—Professor of Pathology, Indiana University (presiding).

Orville T. Bailey, M.D.—Professor of Neuropathology, Indiana University.

Robert Heimburger, M.D.—Associate Professor of Surgery and Chief of Neurosurgery, Indiana University.

Philip White, M.D.—Assistant Professor of Neurology, Indiana University.

Harry Boyd, M.D.—Chief Resident in Neurological Surgery, Indiana University.

Robert Campbell, M.D.—First Assistant Resident in Neurological Surgery, Indiana University.

* Presented March 27, 1956, during the Ninth Annual Symposium on Malignancy sponsored by the Indiana Division of the American Cancer Society at Indiana University Medical Center.

Dr. Harry Boyd: The patient is a 50 year old man, referred to the Robert Long Hospital on April 26, 1955 by Dr. Lewis Curry of Columbus, Indiana. His chief complaint on admission to the hospital was convulsions. The first convulsion occurred six months previously as he was arising early one morning. While sitting on the edge of the bed to put on his socks, he suddenly fell to the floor. At this time, there were jerking movements limited to his left arm, involuntary flexion of the left leg and turning of the face to the left. The convulsion lasted only a few seconds, and consciousness was not lost nor was there incontinence or tongue biting. After the first convulsion, the patient experienced nausea frequently and vomited a few times, early in the morning. He also noticed difficulty in walking with a tendency to stagger to the left. Three other convulsions occurred in the ensuing six month period. During the two months before admission, occasional throbbing pains radiated from the right shoulder to a point just behind the right ear, but no headaches developed. He was unable to work for these two months.

Past History: Twenty-five years before hospitalization the patient contracted syphilis, which was treated with "606," Salvarsan and mercury. Repeated determinations of blood serology since that time were negative. He was in an automobile accident 15 years before admission, and was unconscious for six hours. One year later he had a "black-out spell" of which he could give no description. The patient had tularemia 11 years before admission but recovered without sequelae.

Review of Systems: No symptoms relative to his present illness.

Marital History: The patient was the father of 11 living children.

Physical Examination: Upon admission to the hospital, examination showed a well-developed and nourished man with a blood pressure of 128/90, pulse of 78 per minute, respirations 20 per minute and temperature 98.6°F. The only abnormality was an emphysematous chest.

Neurological Examination: The patient was alert, oriented, cooperative and had no apparent speech defect. There was no papilledema nor constriction of peripheral vision, either to confrontation or by tangent screen examination. There was no evidence of weakness in the facial muscles and examination of other cranial nerve function revealed no abnormalities. On sensory examination, there was hypalgesia over the trunk and extremities on the left side of the body. Stereognosis, figure writing, and two point discrimination were normal. When both sides of the body were stimulated simultaneously, light touch and visual sensations were suppressed on the left. A very slight weakness without incoordination was noted in the left arm and leg. Rapid alternating movements were performed well with the right hand, but poorly with the left. The patient walked with a limited swing of the left arm and circumduction of the left leg. The left triceps, radial and patellar reflexes were more active than those on the right. There was a normal plantar response on the right, but no response to plantar stimulation on the left. There was no Hoffmann's sign.

Laboratory: Blood serology was normal. An electroencephalogram was made on April 27, 1955 the day following admission.

Dr. Smith: Before we ask Dr. White to comment on the electroencephalogram, I would like to ask Mr. Joe Penneybacker to discuss this case.

Mr. Penneybacker: Essentially the problem is one of clinical diagnosis, which would be based on two factors: the location of the lesion, and the nature of the lesion. What has been said of this patient which will answer this? As to its location, I think there is little doubt that the lesion is in the right Rolandic region. Something there is firing intermittently which will lead to abnormal movements of the left arm and left leg in much the same way as they move with electrical stimulation of that part of the brain in an experimental animal. And that really is about all the information we have to answer the first of our two questions.

The second consideration is the nature of the lesion. There are one or two things which we can say about it now. In the first place, there was gradual onset of symptoms and progression of weakness after each attack. This could be due to a lesion confined to blood vessels, such as atheroma of cerebral arteries, or it could be a growing and expanding lesion, such as a tumor. Vomiting is a common symptom of increased intracranial pressure, but in this case it is the only symptom to suggest it. There are other intracranial lesions which might be compatible with the history and

Figure 1.
Pneumoencephalogram before operation. Antero-posterior view.

findings. It could be a gumma. As a matter of fact, his lues was contracted during a time when treatment was not so effective as it is at the present time. It might be an infection, like a schistosome or a hydatid. I have listed only a few possibilities and must wait for more information.

Dr. White: In view of the history of left sided convulsions, we anticipated finding a focus with the electroencephalogram, but we did not. It was an abnormal record, but showed changes on both sides, some of which were rhythmic and synchronous in the nature of slow waves and others which, while slow, seemed to arise independently from one or the other hemisphere, predominantly from the region of the Sylvian fissure on the right. In the absence of a specific focus, however, it seemed likely that this was not a rapidly spreading lesion, such as a glioma. It seemd more compatible with syphilis or a midline neoplasm.

Dr. Smith: You have no indication on the electroencephalogram as to the etiology of the lesion.

Dr. White: Unfortunately not, as this particular type of electroencephalographic abnormality is rather nonspecific and may be seen in a variety of conditions.

Dr. Bickford: I should like to comment on the suggestion that the EEG might show the etiology of the lesion. This is something that the EEG record rarely does. The EEG gives rhythm variations, particularly over cortical lesions, and around 70 to 80% of cortical lesions do produce evidence of their presence, but the EEG does not in itself tell what the lesion is. It will give some idea of the rate of progression of the lesion. Rapidly extending lesions, for instance, are likely to produce a more marked, and much slower frequency change than more chronic lesions. But in this particular case, the evidence is against a cortical lesion. We expect unilateral EEG changes in 90% of cortical lesions.

Dr. Smith: Can we conclude that a lesion exists on both sides when the electroencephalogram

Figure 2.
Pneumoencephalogram before operation. Lateral view.

shows abnormalities on both sides of the brain?

Dr. Bickford: No, that does not necessarily follow, because lesions situated near the midline give projections to both sides. The findings would leave a question as to whether there is a diffuse process in both hemispheres or a lesion in the midline. We have difficulty in distinguishing those two possibilities by EEG. The midline lesion and the diffuse cortical lesion can give rather similar patterns. In this case we would not be certain which of these two it was, but we can be fairly certain that there is no essentially cortical lesion.

Dr. Peyton: This should be a superficial lesion involving the cortex. There is a hemiparesis, not a hemiparalysis, which is well localized. In spite of the EEG changes, I would think this is a cortical lesion.

Dr. Peterson: I do not believe that the plain films add anything to localization or diagnosis. The pineal gland is definitely seen in the lateral projection in normal position. In the PA projections, it is also normal in size and position. There is a dense-looking structure in front of the pineal gland which represents the squamosal suture and has nothing to do with a lesion. The sella turcica looks normal. There is no evidence of increased intracranial pressure.

The next examination is a pneumoencephalogram and gives the localization of the lesion very distinctly (Fig. 1). There is air in both the lateral ventricles, and the right one is flattened downwards with very little shift from one side to the other. A depression of a ventricle with relatively little shift means that the lesion is near the midline, probably just over the ventricle, pushing it down but not crowding it to the opposite side. So we have evidence for a lesion on the right side near the midline on this AP view. In the lateral view (Fig. 2) there is flattening of the right lateral ventricle, quite far back along the body of the ventricle. This flattening tends to place the lesion above the posterior part of the body of the right lateral ventricle. Since the fissure of Rolando starts about 4.5 cm. posterior to the coronal suture, the lesion would be at the beginning of this fissure or just behind

it, perhaps a little nearer the sensory than the motor area.

Dr. Bucy: On clinical grounds, I would agree with Mr. Penneybacker. I would be satisfied with the information which is here, and would expose the region which Dr. Peterson has indicated. I do not believe that it is possible on the basis of these films to make an accurate diagnosis as to the nature of the lesion. There are a number of things which a cerebral angiogram might tell that would help in making a pathological diagnosis. If we assume that this is a meningioma, we might see a ball with a great deal of contrast media in the vessels of the tumor itself. That would be the uncommon type of meningioma. We would be very much more likely to see a tumor with the vessels running around the periphery of a ball. Another possibility would be the presence of abnormal vessels within the tumor mass, evidences of small arteriovenous fistulas, small but tangled, tortuous vessels, which would be much more likely in a glioblastoma multiforme. In addition to these changes, there could be vascular anomalies, not tumors, strictly speaking, which would appear in such patients. In addition to this, we would see the general effects of the mass comparable to what has been seen in the ventriculogram. Instead of the vessels being changed in appearance, they may be displaced. Judging from the pneumoencephalogram, the anterior cerebral artery crossing the corpus callosum probably would dip as it passes above the body of the ventricle. There is not much shift at the midline but there might be some tendency for the anterior cerebral vessel in the antero-posterior view to be dislocated toward the opposite side. You might see some abnormality of the terminal vessels of the middle cerebral artery; the middle cerebral should otherwise be normal.

Mr. Penneybacker: I thought the third ventricle was on the large side, and there is diminished subarachnoid air over the right hemisphere.

Dr. Peterson: This is the lateral projection of the right common carotid angiogram. (Fig. 3). The internal carotid artery comes around the siphon, and the middle cerebral vessels are looped along the lateral surface of the skull. There is a slight downward dip, although this happens now and then without an intracranial lesion. The anterior cerebral artery is normal. Sometimes there is a vessel that follows the back of the corpus callosum and dips down a little more. It may come back up again, which would be an indication that it was actually depressed. In the area where the lesion may be, good filling of the smaller vessels is not seen either now or later and there are no definitely abnormal vessels. There is a vessel which looks as though it surrounds a localized mass. When you see a vessel that wraps around in this fashion it suggests a fairly well localized mass in the area, consistent with a meningioma or a cystic tumor. So this evidence favors a meningioma or a cystic mass that is expanding, rather than a glioblastoma multiforme or a metastatic tumor.

Dr. Boyd: Spinal fluid examination of April 29, 1955 showed:

WBC	0
RBC	253
Pandy	Negative
Total Protein	45
Wasserman	Negative

Dr. Bucy: I would say the spinal fluid is normal, in spite of the 253 red blood cells. The examiner's needle probably tore a small vessel in the spinal canal and got a little blood in the specimen of the spinal fluid. The negative Wassermann test, plus the fact that this man had 11 children rules out the possibility that this was an intracranial gumma.

Following the pneumoencephalogram, this patient got into trouble. I think that is a significant and important thing. Here is a man who, except for his headache and vomiting, had little evidence of increased intracranial pressure. He had no papilledema, and at the time pneumoencephalogram was made, there was no marked increase in pressure of the cerebro-spinal fluid. Yet, after pneumoencephalography, he became drowsy, his pulse became slow and the people in charge of his case felt that something had to be done to relieve his condition. They therefore made holes in the skull, put needles into the ventricles and allowed the air to escape. Patients suspected of having intracranial tumors need to be carefully watched and something done if they get into trouble. For that reason, these tests must be done where the patient can receive definitive care if difficulty arises.

Figure 3.
Lateral projection of right common carotid angiogram.

Dr. Boyd: The patient's positive left Babinski response became more pronounced after cerebral angiography. On May 2, 1955 a right fronto-parietal craniotomy was performed. The bone flap was placed to cross the midline near the vertex of the cranium in order to allow exploration between the cerebral hemispheres. There was considerable bleeding from the bone, the underlying dura mater, and the superior sagittal sinus. When this bleeding had been controlled, the dura mater was opened. The right cerebral hemisphere was then gently retracted from the falx cerebri, and a well circumscribed tumor encountered in the interhemispheric sulcus about 3 cms. from the superior sagittal sinus. The tumor did not invade the cortex, although it was attached to it by a few adhesive bands and blood vessels. When these adhesions had been separated, the tumor was removed in several large pieces. In toto it measured 2 x 3 x 4 cms. The point where the tumor had arisen from the falx measured about 1.5 cm. in circumference. It was coagulated with the electrocautery. The falx was then incised to see if there was more tumor compressing the left cerebral hemisphere. Normal cortex was visualized through this opening, and it was felt that the tumor had been completely removed. The tumor and dura mater were so vascular that a transfusion of 1500 cc. of whole blood was required during surgery.

Dr. Orville Bailey: The histologic picture of the lesion is that of a meningioma. The meningioma arises from the arachnoid cells wherever they occur, whether on the surface of the leptomeninges or in arachnoid villi. The slide (Fig. 4) illustrates how these tumor cells grow. For instance, on the right they sometimes cover the blood vessels, sometimes they merely cover each other. In about 40% of these tumors there are calcified masses called psammoma bodies, as you see on the left.

Dr. Zimmerman: Perhaps you are all familiar with the meticulous book by Cushing and Eisenhardt[1] on the meningiomas. Dr. Cushing summarized his experiences through the years with

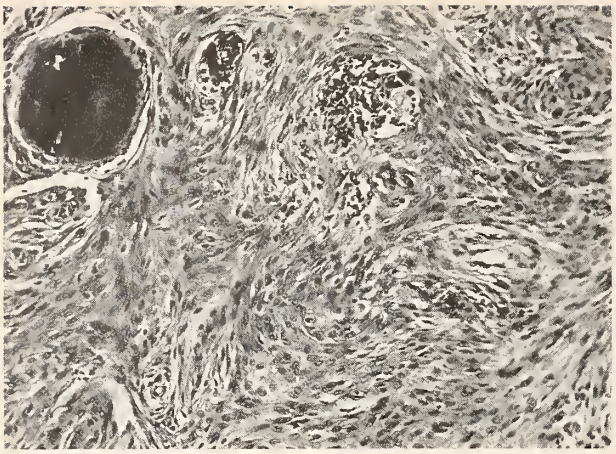

Figure 4.
Photomicrograph of tumor. Low power magnification, H & E stain.

this particular type of neoplasm and arrived, with the aid of Dr. Eisenhardt, at a very detailed classification. For a while most pathologists and neurosurgeons used this as a sort of bible. One type of neoplasm in the classification devised by Cushing and Eisenhardt was the angiomatous meningioma. As a matter of fact, they classified the meningiomas into some nine different types of tumors on the basis of morphology, and it became confusing even to individuals who had considerable experience with this type of neoplasm. A group of us were courageous enough a few years ago to undertake a reevaluation of the classification of this particular type of neoplasm. From a detailed study of about 200 meningiomas we proposed a rather simplified classification.[2] According to it, the tumor which Dr. Bailey described for you would be called a meningocytic meningioma. The simplified classification takes into account the inclusion of certain special types of cells, which are superimposed upon the basic meningocytes. In other words, in some meningiomas there may be rather extensive blood vessel formation; therefore, instead of calling the tumor hemangioblastomatous meningioma, it is simpler to call it a meningioma with an hemangiomatous or vascular component. And in some, there may be a lipomatous component, in some an osteoblastic component, and in other meningiomas there may be other components. The reason it is important merely to designate them as meningiomas with vascular, or osteoblastic, or lipomatous components is because in the same meningioma, we frequently find more than one of these additional factors. Actually, in the tumor under discussion there is a moderately extensive vasculature in the background, but this is by no means so extensive as to justify the designation of an hemangiomatous meningioma. There is very little fibrous tissue without tumor cells in this lesion, so that we would not want to call it a fibrous meningioma.

Dr. Peyton: In spite of the fact that this tumor did not look very vascular in the x-ray, it must have been rather vascular from the standpoint of the surgeon. The scalp and bone and other tissues bled profusely. The surgeon has learned not to be fooled with the x-ray appearance and the angiogram. I would be sure that this was a benign meningioma and the prognosis good. If the surgeon told the truth, he took it all out. This, of course, includes the removal of the dura at the site of its origin. I presume it was completely removed, and he should be cured permanently.

Dr. Smith: How many years ago, Dr. Heimburger?

Dr. Heimburger: One year ago.

Dr. Smith: Is that long enough to say he is out of the woods?

Dr. Peyton: No, the tumor might recur only after 20 or 30 years. Meningiomas that are possibly incompletely removed should be permanently watched, because they may recur. If this tumor does recur, it will probably be in a very slow, gradual manner.

Dr. Bickford: How is it that this man could have seizures suggestive of motor cortex irritation from a lesion situated in the parasagittal region? There seem to be three possible explanations. First, that the tumor by displacement had actually caused compression of the right motor cortex with the associated irritative phenomenon of a Jacksonian seizure. Secondly, that the seizures arose from Penfield's supplementary motor area which is situated close to the medial surface where the tumor was actually found. This explanation seems unlikely, however, since a seizure produced from this area is more complex and usually associated with head turning, and without the features of the simple Jacksonian attack. A third, and to my mind more likely, hypothesis is that the seizures represented an irritative effect on the right pyr-

amidal pathways near the internal capsule. While irritative effects on tracts are not a usual cause of epilepsy, I firmy believe that such effects do occur, this being analagous to the artificial synapse of the damaged peripheral nerve. It is this mechanism that is most likely to account for the seizures, which could be termed psuedo-Jacksonian.

Mr. Penneybacker: There is an unusual pattern in this particular case, for a tumor of the falx is not a parasagittal meningioma but lies on the medial surface of the hemisphere. It may be difficult to understand how it is that a lesion in this situation affects the arm in the first instance rather than the leg. Why did he not start with the much commoner manifestation of this type of tumor in this situation; that is, motor or sensory epilepsy in the lower limb? However, we have seen it on many occasions, and whether it is referable to any of the explanations that have been advanced, I do not know. This man is very lucky to have got into the right hands—the hands of a skillful surgeon, because 90% of people that have this type of tumor in this situation fetch up in a much worse state, notably as regards weakness of the lower limb.

Dr. Peterson: How important is it to have added examinations like the angiogram when you know where the tumor is after the pneumoencephalogram?

Dr. Bucy: I still feel as I did that the localization with the pneumoencephalogram was sufficiently accurate to permit one to operate on that basis alone. But that is not invariably the case. There are times when about all one can be sure of is that the tumor is on one side of the brain and not on the other. In such cases, an angiogram can be very valuable in guiding the surgeon in making his exposure. This is much more valuable than the utilization of the angiogram to determine the type of lesion because it is only in the exceptional case that one can be confident as to the type of lesion from the angiogram. In the majority of instances, you get localization rather than pathological diagnosis.

A first rate job was done here from the time this patient came in to the hospital to the time that he left. On the other hand, what was done here was perfectly routine. This is exactly what should have been done. The important thing occurred before this man ever reached the hospital and that was the recognition by Dr. Curry of Columbus, Indiana, that this man had a lesion which could be corrected by proper treatment; that this man was not just another epileptic who should have some bromides or phenobarbital and be sent on his way. Such measures probably could have stopped the attacks temporarily. The man would have gone on his way, possibly with no more attacks for several years; yet in the meantime, his tumor would have gotten bigger and bigger until the man's condition was far more serious than it was when he came in. An adult 50 years of age, for the first time in his life, developed a convulsive seizure. By all odds the most common cause for this is a brain tumor. The convulsive seizure was a localized phenomenon involving only his left side. This meant almost certainly that we were dealing with a localized lesion. Now those two facts together, quite apart from anything else, leaves little doubt that one is dealing with an intracranial tumor and that the sooner it can be removed, the better. The other point I want to make is, that tumors are difficult to remove when they extend down between the two hemispheres and press on the thalamus.

ADDENDA

The patient failed to keep post-operative appointments and was not seen after discharge until 3-27-56 when he reported that he became easily fatigued and unable to concentrate. He was able to drive a truck for a contractor. He had had several mild left sided convulsions, about which he was unconcerned. EEG showed diffuse irregularities and indicated that his cerebral function had deteriorated. Anticonvulsant drugs were prescribed at that time, but he did not take them and failed again to return for follow-up.

On 7-24-56 he came to the Out-Patient Department with the complaint of generalized headache, fatigability and weakness of both lower extremities. He frequently dropped objects from his left hand without meaning to. He had three generalized convulsions during July, 1956.

The patient was readmitted to the hospital on 7-30-56 and was found to have noticeable weakness of the left foot with circumduction gait. There was no papilledema, weakness of the left arm, or other neurological deficit. Cerebral angiogram 7-31-56 again showed separation of the

pericollosal and supra-marginal branches of the right anterior cerebral artery, indicating a mass between them. On 8-6-56 another meningioma measuring 7½ x 6 x 3 cm. was removed. It was also attached to the falx cerebri just anterior to the motor cortex. A large segment of the falx was missing as the result of the previous operation, and the tumor arose from the anterior lip of this defect.

Following surgery the patient had a left hemiplegia from which he gradually recovered. On 10-23-56 when he returned to the Out-Patient Clinic he had circumduction of his left leg when walking, but no weakness or incoordination in the left arm. He had not returned to work.

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The Papanicolaou Smear Technique to Detect Early Cancer in Cervix Uteri: A Report on Its Use in General Practice

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Greensburg

THIS PAPER IS WRITTEN to encourage the every-day use in the general practitioner's office of the Papanicolaou smear technique for the detection of early cancer in the cervix uteri. If cancer of the cervix is to be detected early, it is in the general practitioner's office where it should first be found. Now, with the "Pap smear" technique available to any doctor, it is entirely possible and practical, and I might say, morally mandatory, that the general practitioner take the trouble to use this method, and with the help of a good pathologist, roentgenologist, and surgeon, make far advanced cancer of the uterine cervix, in patients who give him the opportunity, a thing of the past.

It is apparent, or should be apparent, to anyone who has looked at many uterine cervices that, from the standpoint of detection of early cancer of the cervix, the appearance of the cervix means nothing. Lacerations, erosions, granulations, polyps, cysts, and exudates, might make one suspicious, but, oftener than not, these abnormal-looking cervices do not turn out to be malignant. But when you see a relatively normal-looking cervix and get a "Pap smear" of it showing Class III cells, followed by a biopsy showing carcinoma in situ, or early invasive stage, you are impressed with the efficacy of this method of detection. How else would such a patient ever have been led to early treatment and probable cure? This is the type of case that makes it imperative and morally obligatory to do a "Pap smear" on every cervix examined. It has been said that one case proves nothing; but, in this instance, at least for this patient, one case is all that is needed to save her very life, and for her and for me, it is all that is needed to prove the efficacy of the use of the "Pap smear" technique for this particular cancer in this particular location.

It should be interesting to know just what to expect if the doctor does "Pap smears" on all uterine cervices he examines. With this in mind, I reviewed the results of the "Pap smears" I obtained in my office for a four-year period from 1948 to 1952. The smears and biopsies were examined by Dr. David Adler, of the Pathology Department of the Bartholomew County Hospital of Columbus, Indiana.

It should be said that the technique of obtaining a "Pap smear" and treating it and preserving it until the pathologist gets to it is all-important in evaluating any results of studies—the "Pap smears" in the study were obtained, processed and preserved according to the method described in the film on "Precancer Diagnosis of the Cervix by Cytology," by the American Cancer Society, obtainable from the Indiana Cancer Society for showing to professional groups.

This study includes 491 "Pap smears" obtained on 360 patients. Of these 491 smears, 399, or 81.3%, were reported as showing Class I cells. Of the 399 Class I "Pap smear" reports, 233, or 55.5%, came from normal-looking cervices; 176, or 44%, came from abnormal-appearing cervices; there were no malignancies and no biopsies.

Of the total 491 "Pap smears," 51, or 10.4%, were reported as showing Class II cells. Of these 51 Class II reports, 10, or 21.4%, came from normal-appearing cervices; 40, or 78.4%, came from abnormal-appearing cervices; there were three biopsies in this group—all reported negative for malignancy.

Of the total 491 "Pap smears," 36, or 7.3%, were reported showing Class III cells. Of these 36 Class III reports, 6, or 16.7%, came from normal-appearing cervices; 30, or 83.3%, came from abnormal-appearing cervices; there were 17 biopsies, 3 of which were reported as positive for carcinoma of cervix.

Of the 491 "Pap smears" obtained, 5, or 1%, showed Class IV and Class V cells. Of these 5 Class IV and V reports, 1 came from a normal-appearing cerxiv; 4 came from abnormal-appearing cervices. All 5 of this group were biopsied, and there were 4 malignancies found. I should state here that the biopsy of the one patient whose Class IV cells came from a normal-appearing cervix, was one of the positive biopsies, showing intra-epithelial carcinoma.

The facts pertinent to this study of the cases who showed Class III, IV and V cells, who had malignancies, are given below. (The patient who had Class IV cells and didn't prove to have a malignancy is also included).

Case I—Age 32. Examined on June 12, 1950. Cervix appeared eroded about external os—"Pap smear" reported showing Class IV cells. Patient was referred to I. U. Medical Center for biopsy of cervix. She was followed in I. U. Medical Center Clinics for two years. Was next seen by me on August 7, 1952, at which time "Pap smears" of the cervix were reported showing Class I cells.

Case II—Age 39. Examined first on July 2, 1951, because of bloody discharge after intercourse. The cervix presented erosions on anterior and post lip of cervix. "Pap smears" of the cervix were reported Class I cells. The erosions were cauterized and the patient was not seen again until March 17, 1952, with the same complaints. The cervix was enlarged and eroded. "Pap smears" at this time were reported Class II cells, with rare suspicious cells and recommended repeat smear and biopsy. The repeat smear on March 29, 1952, showed Class V cells, and biopsy showed early invasive carcinoma, or Stage 1, of League of Nations classification. This patient received radium to cervix, followed in one month by total hysterectomy and oophorectomy. "Pap smears" of vaginal vault on June 30, 1952, showed Class III cells. The patient did not present herself for check-up again until January 3, 1953, at which time "Pap smears" of vaginal vault still showed Class III cells. On April 5, 1953, smears of vaginal vault showed Class II cells. In November, 1953, smears of vaginal vault showed Class I cells. This patient has remained well up to the present time and is presumed to be cured.

Case III—Age 23. Was examined on November 27, 1950, because of menstrual irregularity and vague lower abdominal complaints. The cervix had erosions, anterior and posterior lips, and the posterior lip bled easily on scraping by tongue blade. "Pap smears" were reported Class IV cells. Biopsy obtained on December 4, 1950, was reported intra-epithelial carcinoma of cervix. On December 22, 1950, patient received radium treatment to cervix. On January 12, 1951, total hysterectomy was done. Because of lack of cooperation of patient, no check-up smears were obtained in follow-up, but it is known that patient has remained well to date.

It is interesting to note that, in this case, a "Pap smear" of the cervix was obtained in March of 1949, routinely in post-partum check-up, and showed Class I cells, although the cervix was markedly eroded at that time.

Case IV—Age 32. First seen April 23, 1952, because of flooding. Examined May 1, 1952, cervix showed what appeared to be a small granulation on posterior lip within external os. "Pap smears" revealed Class V cells. Biopsy obtained on May 6, 1952, was reported squamous cell carcinoma cervix, Grade 3. On May 13, 1952, this patient received radium treatment to cervix, followed in approximately 6 weeks by deep X-ray therapy to pelvis. Pelvic check-up on September 10, 1952, "Pap smears" showed Class I cells. Smears of the cervix at approximately six-month intervals up to the present time have been reported Class I cells.

Case V—Age 44. First examined on March 5, 1949, as part of general physical check-up. Cervix showed healed lacerations and erosions. "Pap smears" reported Class III cells. On March 15, 1949, biopsy of cervix reported as squamous cell carcinoma of cervix which has infiltrated the cervical stroma. On March 29, 1949, patient received radium

CHART SHOWING DISTRIBUTION, RELATIVE TO CLASS OF CELLS AND APPEARANCE OF UTERINE CERVIX, OF 491 PAP SMEARS OBTAINED ON 360 PATIENTS

	CLASS I	CLASS II	CLASS III	CLASS IV & V
No.	399 or 81.3%	51 or 10.4%	36 or 7.3%	5 or 1%
Normal-appearing Cervix	233 or 55.5%	10 or 21.4%	6 or 16.7%	1 or 20%
Abnormal-appearing Cervix	176 or 44.1%	40 or 78.4%	30 or 83.3%	4 or 80%
Biopsy	None	3	17	5
Carcinomas	None	None	3	4

treatment to cervix. On April 22, 1949, total radical hysterectomy and oophorectomy was done. On May 23, 1949, patient began deep X-ray therapy to pelvis. "Pap smears" of vaginal vault in follow-up approximately every six months were reported Class I or II cells, until February 4, 1952, at which time patient refused to have further follow-up, but it is known patient remained well until 1955, after which she moved to a different town.

Case VI—Age 51. First examined on August 1, 1951, as part of general physical check-up. The uterine cervix appeared normal. "Pap smears" revealed Class III cells. Cervical biopsy reported early carcinoma of cervix. On August 30, 1951, had radium treatment to cervix. On September 22, 1951, had total hysterectomy and oophorectomy, followed in approximately one month by deep X-ray therapy to pelvis. Following this, approximately 4 months, patient had apparent radiation reaction in colon and rectum, which persisted for about a year and was characterized by blood in stool and much pain in rectum at intervals. Unfortunately, the "Pap smear" follow-up on this case has been lost and was not obtained at regular intervals, but it is known that patient has remained well up to the present time.

Case VII—Age 21. Was examined on July 23, 1949, as part of six-weeks post-partum check-up. The uterine cervix showed slight erosion. "Pap smears" reported Class III cells. Biopsy on August 20, 1949, was reported intra-epithelial carcinoma of cervix. This patient was referred to Indiana University Medical Center for definitive treatment. It is interesting to note that a "Pap smear" obtained at the time the biopsy was taken was reported as showing only Class I cells. At Indiana University Medical Center, a total hysterectomy was done, and patient was presumably cured. "Pap smears" of vaginal vault at a Cancer Detection Clinic at Batesville, Indiana, on May 1, 1950, revealed Class I cells. This patient has not had consistent follow-up, but was known to be living and well, as of March, 1955.

Interpretation:

Class I: Absence of abnormal or atypical cells. Negative.

Class II: Atypical cells present but without abnormal features. Negative.

Class III: Cells with abnormal features but not sufficiently pathognomonic. Suspicious.

Class IV: Fair number of pathognomonic cells and cell clusters. Positive.

Class V: Large number of conclusive cells and cell clusters. Positive.

SUMMARY

In summary, a plea for the more generalized use of "Pap smear" technique in detection of early cancer of the cervix has been presented. Results of review of 491 "Pap smears" taken on 360 patients have been described and tabulated as to appearances of cervix and frequencies of occurrence of the five types of cells reported on "Pap smears". The facts pertinent to cancer of the cervix in 7 case histories of cancer of the cervix have been presented.

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George N. Lewis, M.D., Gary	Dec. 31, 1959
Samuel R. Mercer, M.D., Fort Wayne	Dec. 31, 1959

Editorial Secretary: Jeanne S. Grover, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

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CARCINOMA OF THE COLON

OBSERVATIONS during recent years on the natural behavior of carcinoma of the colon give promise of improving the results of surgical treatment. Studies of resected specimens of colonic cancer and the location of recurrent (or more properly persistent) tumors after resection of bowel prepared by modern methods, have both suggested improvements in operative technique.

It has long been recognized that some carcinomas of the large bowel metastasize by way of blood vessels. However, it was thought that the great majority of such lesions spread through the lymphatics, and that not more than 10 percent or at the most 15 percent invaded the veins of the mesentery. Operative procedures were accordingly planned with a primary purpose of removing a maximum amount of the lymphatic drainage of the area involved. A minimum amount of attention was accorded the venous element since it was thought that if the blood vessels did contain tumor cells they would have been swept through the portal system and into the liver prior to the operation.

Recent pathologic studies have shown by an ingenious technique of X-ray visualization of the venous pathways in a resected specimen of mesentery and subsequent microscopic sections of obstructed veins that between 40 percent and 50 percent of colon malignancies have invaded the mesenteric veins prior to the time of resection.

Other investigators have perfused the mesenteric veins of resected specimens and have been able to identify malignant cells in the vein washings in a large number of cases. The inference is that manipulation of the tumor will initiate or increase migration of the carcinoma cells into the veins.

Such observations have prompted Warren Cole to advocate isolation and ligation of the blood supply as the first step of the operation whenever this is possible. His recommendation is made with the thought that palpation of the

tumor and pressure upon it incident to mobilizing it, may be sufficient to dislodge malignant emboli and allow their passage beyond the limits of the operation, unless the veins are tied as the first step.

During the period in which resection of the colon has been performed with intraluminal antibiotic preparation and a resulting practically sterile lumen, several investigators have been impressed with the apparently increasing number of recurrent malignancies which have occurred at the line of anastomosis.

There have also been reports of apparent satellite tumors which have arisen after bowel sterilization and prior to operation.

How these phenomena occur is not understood at the present time, but the implication is strong that tumor cells are desquamated, and in a prepared bowel are able to implant and survive at any point in the bowel which is ulcerated or injured, as for instance at the suture line.

This makes it advisable to isolate the lumen of the colon on each side of the lesion by the application of tightly drawn heavy sutures which include the entire circumference of the bowel. This is also a part of the operation which should be accomplished as soon as possible, and before manipulation of the lesion, if this is feasible

Further study of the ability of a carcinoma to implant secondary deposits in a surgically prepared colon is indicated and will no doubt be carried out. It may develop that preoperative bowel preparation is not an unmixed blessing. A whole field of research is opened up for alternative methods and new anti-bacterial agents if this behavior of colonic carcinoma is verified.

MEDICAL EDUCATION WEEK

THE MEDICAL SCHOOLS of the United States are scheduled to receive a lot of favorable publicity during Medical Education Week from April 21 to 27. Medical societies and auxiliaries, civic groups, newspapers, radio and television networks will cooperate in a campaign to educate the public on medical education.

The purpose of the observance is to focus attention on the national importance and indispensability of medical education. A well-organized program of public information will bring about greater friendship and support for the medical schools by creating a better understanding of their aims, problems, achievements, and public services.

President Eisenhower, in his personal endorsement of the program, said, "While the benefits of health and medical education are daily with us, it is fitting to devote a special week to the consideration of the wider training of physicians. Each American has a personal stake in our country's medical schools. The schools which train physicians required by our growing population are a vital resource for the health of our people and the strength of the nation."

The goals of the program are:

1. To portray the key role that medical education plays in the promotion and maintenance of the nation's health and security, and make the public aware that the nation's 82 medical schools are the foundation of our entire health and medical structure.

2. To explain how the medical schools are striving to meet the demand for larger numbers of physicians and, at the same time, to maintain the high standard of training that has come to characterize American medical education.

3. To call attention to the steady progress in the medical sciences, showing what this means in terms of longer life, better health and greater freedom from disease and disability.

4. To point out the wide range of activities—teaching, research, service and leadership—car-

ried on by the modern medical school in addition to its job of training new doctors.

5. To make clear the extent and nature of the new challenges to the profession, some growing out of our constantly expanding fund of medical knowledge and some resulting from the mounting complexity of our civilization.

6. To point out some of the steps being taken constantly to push back the horizons of the medical sciences and to realize the full potential of the nation's health resources.

While medical societies and medical schools throughout the country build community programs around these objectives, the national sponsors—the AMA and the Woman's Auxiliary, the Association of American Medical Colleges, the Student AMA, the American Medical Education Foundation, and the National Fund for Medical Education—are enlisting the help of newspaper syndicates, radio and television networks, popular and professional publications, civic groups, industry, and commerce in a broad program of national publicity and promotion.

Consequently, it seems inevitable that during Medical Education Week the American people will hear that medical schools are enrolling more students, graduating more physicians, and performing greater research and services than at any previous time in history.

Guest Editorial:

THE QUICK AND THE DEAD

PHYSICIANS WHO TREAT auto accident casualties should be definitely dissatisfied with the role of patching up and rehabilitating human wrecks. The business of making cars safer, roads super, and careless drivers suffer is not theirs. Progress has already been made in these areas without proportionately reducing the accident toll. If the number of dead and maimed is to be reduced, an attack must be made to reduce the number of unfit drivers. A bottleneck exists within the area of the driver's physical characteristics and more importantly, within the area of personality.

Officials of the Registry of Motor Vehicles do a passing good but limited job of weeding out the physically inadequate among driver candidates. This work should be transferred to the medical profession, and its scope extended.

A system should be devised whereby the responsibility for determination of physical fitness to drive an automobile is arrived at only after adequate medical opinion. We see no reason for not expecting all drivers to pass periodic physical examinations as searching as those required of truck drivers or of airplane pilots. The record dictates the need. Operating licenses should be issued with the advice of a medical board whose members review the reports of the applicant's physician. No careful driver should have to travel on the same highway with a driver who has tunnel vision, both legs in casts, or a history of disabling cerebro-vascular accidents.

Considerations of physical integrity, however, are, by comparison with personality defects, relatively trivial. Studies made by McGuire (Frederick L., Naval Medical Field Research Laboratory, Camp Lejeune, N.C., 1955) have shown that accident-prone drivers are different people from the relatively accident-proof. They have different likes and dislikes, spend their spare time differently, and put different values on various facets of living. More often than not the safe driver has been found to be religious. Further study of the pertinent stigmata and emotional variables of all drivers would seem to be within the province of medical men, with a view to curbing those temperamentally unqualified and to rehabilitating those not incorrigible.

This appraisal of the emotions would eventually take on the coloration of something like the present aptitude testing of the vocational guidance counsellors. Acceptable standards would have to be devised, revised, and authorized to grade driving safety. Even if it were to take a long time to establish itself securely, this system should prove as helpful in showing up misfits on the road as vocational testing is in showing up misfits on the job. The growing pains of accident prevention should not be harder to bear than the pains of accidental destruction.

—*Massachusetts Physician*

The President's Page

A.M.E.F.

THE AMERICAN MEDICAL EDUCATION FOUNDATION was founded in 1951 in association with the National Fund for Medical Education, the latter a lay movement for contributions to our medical schools for furthering medical education. This past year, 1956, saw a change in relations of the two organizations in that the funds were kept separate. However, one complicating factor has arisen, and that is the matching funds being donated this year directly to the schools by the Ford Foundation will not be matched by the Ford Foundation. This would result in a sum of approximately $120,000 less than under the old system. In order to make this up and so that the schools will not be penalized by the change to the new system, the Board of Trustees of the American Medical Association has appropriated an additional $125,000. This with the $100,000 already appropriated and $118,000 for all the expenses of the Foundation fund drives and its educational programs will add up to the sum of $343,000 from the A.M.A. Note that all donated money goes to the medical schools—none for administration.

On December 31, 1955, the A.M.E.F. transferred to the medical schools through the National Fund for Medical Education $1,120,429 to make a total of $4,684,312 that has been distributed to eighty-two medical schools of the country by the American Medical Education Foundation since 1951. Parenthetically, it may be noted that the grants to Indiana University School of Medicine lead the rest with $230,534.61. This enviable position is probably due to Indiana's early participation in this movement under the leadership of Dr. Jim Denny, wherein we obtained an early favorable position. Unfortunately, this position has not been maintained, but possibly may be regained with effort and cooperation.

For one thing, it must be distinctly understood that this movement is not a hit-and-run affair, but is on a continuing basis. As we must eat every day, so the medical schools require financial fodder to keep them going. Medical school tuition is the highest of any type of school, but must be supplemented by donations or other income. Perhaps part of the difficulty has been that at the outset, three-year pledges were obtained, and at the conclusion of that period, many of the pledgers did not renew nor contribute further. There was a sharp decrease at the end of the initial 3-year period.

We truly may be proud of the great work being done in this field by our Woman's Auxiliary. The National Auxiliary, of which Mrs. Frank Gastineau was chairman of A.M.E.F., raised in the last fiscal year (July 1, '55—June 30, '56) a wonderful total of $106,223, Indiana's share in this gift being $8,703. In that time, Mrs. Francis Fargher was North Central Regional Chairman.

Awards of Merit for 1955 went to the Woman's Auxiliary to the Indiana State Medical Association, the Woman's Auxiliary to the Indianapolis Medical Society and to the Woman's Auxiliary to the Lake County Medical Society. We certainly appreciate all the work these awards represent.

Medical Education Week this year is April 21-27, inclusive, and we should like a special effort to be made to improve our standing in this important work. Besides direct contributions and pledges there are many other ways to increase our totals, and we feel sure that you will soon be approached in one way or another to participate in some of these plans. Dr. Harry E. Klepinger of Lafayette is this year's Chairman of the Committee on Medical Education and Licensure. Remember that you may specify your gift is to go to any particular medical school, or for specific purposes, such as Heart Research, Cancer Research, Epilepsy and so on. Your gifts should be sent to A.M.E.F., Indiana State Medical Association, 1021 Hume Mansur Building, Indianapolis 4.

The aims of the A.M.E.F. are to supply additional needed funds and obviate the necessity for federal aid and consequent federal control of Medical Education. This should be kept in mind as an incentive to continued efforts.

Elton R. Clarke, M.D.

The Tumor Registry at Indiana University Medical Center

E. J. DONLAN, M.A.*

Indianapolis

As of January 1, 1956, a requirement of the American College of Surgeons for approval of a cancer program specified that a properly functioning cancer registry be in operation. A cancer or tumor registry is an active repository of abstracts or records of the total cancer experience within an institution from a given date. The intent of such registration is to have available a file of medical record abstracts and follow-up of each cancer patient for teaching, evaluating, research or reporting purposes; to provide a systematic follow-up for all cancer patients to keep them under adequate medical observation as long as they live; and to report to the staff annually their cancer salvage rate.

The interest of evaluating cancer data separate from the hospital medical record had its inception at the Indiana University Medical Center in the late thirties. This comprised a medical record abstract of cancer cases seen in the tumor clinic and other cases of specific interest to individual therapists. Follow-up was pursued primarily on select cases. This method of collecting data furnished barely one-fourth of the total cancer load.

With the increase of investigation in the cancer field and the demands for inclusion of the entire hospital cancer case load with regular continuous follow-up, a system was devised through the cooperative efforts of representatives of the Indiana State Board of Health, the National Cancer Institute, the American College of Surgeons and existing registries to incorporate such data on punch cards. Since January 1, 1952, all cancer cases, private and public, inpatient and outpatient, seen in the Wm. H. Coleman, Robert W. Long and James Whitcomb Riley Hospitals of the Indiana University Medical Center have been recorded in the Tumor Registry.

Registration entails preparing a medical record abstract with a resume of diagnosis, treatment and subsequent pertinent information. Data of sociological, medical and follow-up character are entered on a structured worksheet for coding purposes. Of social significance are items pertaining to age, sex, race, marital status as well as familial history of cancer. The medical component of the worksheet includes the site of the primary lesion coded according to the International Statistical Classification of Diseases, Injuries, and Causes of Death of the World Health Organization; the histological type of neoplasm derived from a modified Standard Nomenclature of Diseases and Operations Classification; the stage of disease on the basis of in-situ, localized, regional involvement, remote and disseminated; and the types of therapy given at this institution. In addition to the above data, details as to previous therapy performed, method of diagnosis utilized, microscopic confirmation of the neoplasm and clinical evaluation of carcinoma of the cervix by stage as accepted by the League of Nations Health Organization are elicited. On the follow-up section of the code worksheet is entered the source of contact as to verification of medical examination or other means, interim therapy undertaken elsewhere, the additional therapy given at this hospital, evidence of recurrence, the status of the disease on the basis of cancer free or with cancer as well as the survival in years from the date of the original diagnosis, the underlying (primary) cause of death

* Statistician-in-charge, Tumor Registry, Office of Cancer Coordinator, R. J. Rohn, M.D., Indiana University Medical Center. The Tumor Registry is supported in part by funds from a cancer teaching grant CT-5044, National Cancer Institutes, United States Public Health Service, and the cancer activities program, Indiana State Board of Health.

TABLE I
INDIANA UNIVERSITY MEDICAL CENTER
CANCER INCIDENCE 1952-1955

SITE	NUMBER	PER CENT
CERVIX, UTERUS, OVARY	351	16
LEUKEMIA, LYMPHOMA	294	14
LARYNX, LUNG	268	12
ESOPHAGUS, STOMACH, LARGE INTESTINE, RECTUM	268	12
SKIN	194	9
PROSTATE	79	4
BREAST	129	6
ALL OTHERS	507	24
BRAIN, NERVOUS SYSTEM	64	3

as given on the death certificate and whether autopsy performed.

During the four year period, 1952-1955, the Tumor Registry of the Medical Center recorded 2,154 cancer cases that were seen in the aforementioned hospitals. Two-thirds of this total cancer case load were other than private patients. Therapy for cancer had been instituted in approximately 1 out of 5 cases before entry here. Private cases constituted 43 per cent of the previously treated group and 30 per cent of the group without prior treatment. In those first seeking treatment at the hospitals of the Medical Center, the stage of disease had progressed to regional and greater extension in approximately 3 out of 5 cases. Slightly more than one-half of the non-previously treated private cases had regional and greater extension of their disease. The diagnosis of cancer was substantiated by microscopic verification in 93 per cent of the total case load.

The greatest incidence of cancer occurred in the female genital organs as shown in Table I. Malignant tumors of the cervix comprised 64 per cent of this group and ranked first by specific site. Of the total female genital organ cases there were 256 patients, 110 private and 146 non-private, that had received no prior treatment for their disease. Patient cases within the leukemia and lymphoma group were about equally distributed between the two entities, 157 and 137 cases respectively. A steady rise in the incidence of this group at this institution has been noted over the periods of registration and the tendency appears to be toward a natural increase rather than due to better recognition of the disease and special medical facilities. Diagnosis was confirmed by histology and exfoliative cytology in 92 per cent of the leukemia and lymphoma cancer cases. Malignant neoplasms of the respiratory system accounted for 268 cases of the total cancer load. Primary lesions of the lung were diagnosed in 197 cases, making this organ the second most frequent by specific site in tumor occurrence. Microscopic confirmation of the diagnosis was obtained in 92 per cent of these cases. The incidence of cancer in the digestive system equaled that of the respiratory system. Tumors of the rectum were found in 87 cases or 32 per cent of the total digestive system group, followed by primary sites in the large intestine, stomach and esophagus with 26, 24 and 18 per cent respectively. Malignancy of the breast was diagnosed in 129 cases and ranked sixth in occurrence by specific site. For breast cancer cases previousy treated the number of private and non-private patients was approximately the same, however, in the group without previous treatment, non-private patients were twice as frequent.

Nearly 600 cancer cases are presently seen each year in the Medical Center Hospitals and entered in the files of the Tumor Registry. To establish a body of data sufficiently large to evaluate cancer end results, the cases of cancer admitted in 1945 and later years are being added to the existing punch card system. This evaluation study is sponsored by the Cancer Chemotherapy National Service Center of the National Cancer Institute, United States Public Health Service. Interpretation of survival rates and evaluation of therapy will be undertaken at a future date as collection of data grows.

The Registry maintains active follow-up on approximately 2,000 old cases. Follow-up requires continuous contact at regular intervals with each case as long as the patient lives and the recording of the pertinent data on the individual case record. The length of time from the initial therapy to the first follow-up never exceeds six months and contacts are made thereafter at intervals of six months to a year. The mode of contact is predicated by the type of patient admission, i.e. private or non-private, and the physical condition of the patient at discharge. Names of advanced cancer cases are checked against a monthly roster of Indiana deaths submitted to the Registry by the Tabulation Section of the State Board of Health. Correspondence is directed to private physicians on patients under

their care. The other cancer cases are followed through visits to the outpatient clinics and subsequent admissions at this institution, and by correspondence with the patients and agencies interested in their welfare. The level of follow-up has been maintained almost consistently at approximately 99 per cent, in spite of the fact that two-thirds of the procedure is carried out through correspondence. However, one-third of the cases in this category are actively followed by their local physicians whose splendid cooperation in providing medical fact is enabling the Registry to accumulate adequate data on the natural history of cancer. It is felt that through the instrumentality of the Registry that numerous cases would have deferred seeking further medical assistance, not only for the cancer but other diseases, if it were not for its persistence in follow-up.

Acknowledgment: The Registry is indebted to the Indiana State Board of Health for the contribution of the services of its Tabulation Section for the mechanical punching of the data cards and for the collaboration of all departments of the hospital in the program, specifically the Medical Records Department in furnishing the medical charts of cancer patients and the Pathology Department in submitting pathological reports to the Registry on each case with a cancer diagnosis. To these and to all who have contributed to the function of the Tumor Registry we wish to express our gratitude.

"THIS IS WHERE WE CAME IN"

That's the title of an "Editor's Page" editorial in the current issue of the attractive Bulletin of the Los Angeles County Medical Association. It was written by Editor William F. Quinn, M.D., and deals with a rehash of the 14-year-old compulsory health insurance proposal which has once again landed in the Congressional hopper—thanks to Senators Murray and Dingell.

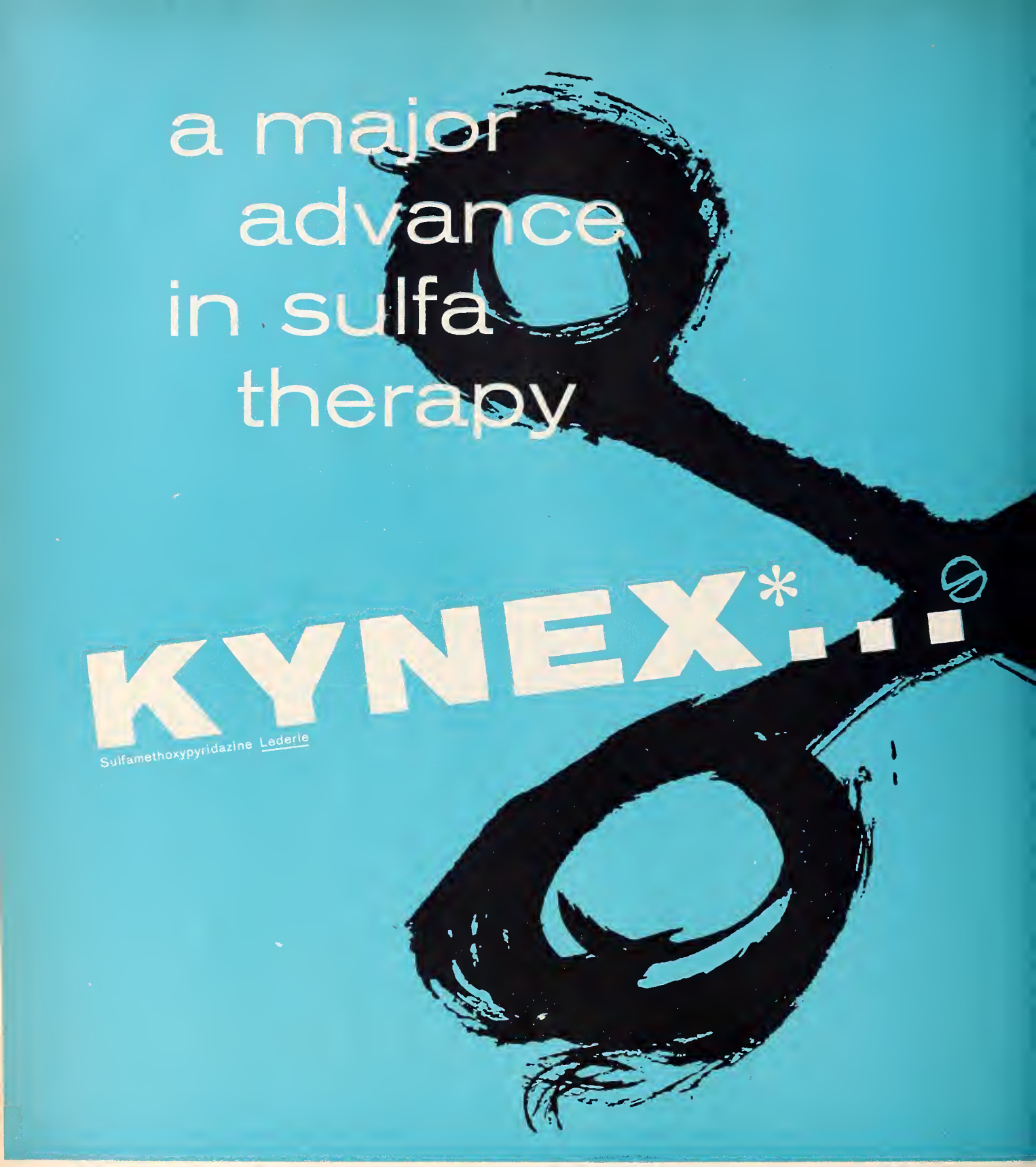
Bill Quinn penned a powerful and forthright message, saying among other things:

"While reasonable men might assume that a record of more than 50 hearings, filling 10 large volumes of testimony by competent witnesses, could lead to the assumption that the subject had been thoroughly explored and its glowing promises exposed for the mirages they are, unfortunately, it would be naive to assume that this, like a second marriage, may represent the triumph of hope over experience."

Bill explained some of the provisions of the proposed compulsory scheme. "The ultimate authority is the Secretary of Health, Education and Welfare, who shall make rules and regulations," he said. Then he added:

"Dissatisfied patients may complain through channels and ultimately reach the Supreme Court. This might be analogous to receiving permission to perform a therapeutic abortion eight months after the request was made."

—*A.M.A. Secretary's Letter*



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The Social Worker and The Tumor Registry

BETTY L. POWER, M.A.*

Indianapolis

IN THE PROCESS OF KEEPING an accurate, up-to-date record on the tumor patient, many problems come to light which cannot be handled in a routine manner. For those problems pertaining to the ability of the patient to cope with his illness, to make the best use of medical care, to carry out medical recommendations, and the use of the most appropriate community agency, a referral to the medical social worker is indicated. Although the services of a social worker were available to the Tumor Registry staff just as to any other Medical Center activity, not until a medical social worker was assigned to the tumor program in the summer of 1950 did social service become integrated with the Tumor Registry.

The role of the social worker in relation to these problems encompasses three broad categories of services. The first of these is medical social casework. This is a professional service based on scientific knowedge, and skill in understanding human relations. With this knowledge and understanding, the medical social worker interviews the patient and his family to help them express their fears, hopes, and aspirations in relation to the illness and its treatment. She then uses this verbalization to help the patient and his family to a better understanding of the patient and his needs and to accept and plan for any necessary adjustments in attitudes and environment, as well as limitations in order that the patient live as satisfying and useful a life as is possible. The other two categories of services are aid in locating patients and in obtaining current information concerning them, and consultation services to the staff of the Tumor Registry. They are not isolated one from the other and one referral may require them all in the course of solving a particular probem.

The category of casework services is, from the patient's standpoint, the most important service. Here the medical social worker utilizes her special skills in working directly with the patient and his family by means of interviews and correspondence to help him find the best solution possible to his problems. Casework services are geared primarily toward helping patients accept and carry out treatment recommendations. Mr. H. is a case in point. He signed himself out of the hospital when he learned that he would need a colostomy. The Tumor Registry staff noted this as it routinely "picked-up" the case and subsequently referred him to the social worker. The social worker found him to be a lonely, frightened old man. He had no close family ties; he lived on a very modest pension in a rooming house. Because he took great pride in his appearance, he was afraid others would notice an odor or see that he was "different." Too, he was afraid that surgery would mean a nursing home and the end of his independence. The social worker recognized his feelings, and worked with his doctors in helping him to understand what the proposed surgery was expected to accomplish and how it would affect him. He was given opportunity to ask questions, and feel in control of his own being. When he did agree to surgery, he accepted this decision as the right decision for him. During convalescence he was given the interest and support he needed to help him regain his independence. Prior to his discharge from the hospital, with his consent, appropriate community agencies were alerted and he returned to his room,

* Assistant Casework Supervisor, Social Service Department, Indiana University Medical Center; Field Work Instructor, Indiana University Division of Social Service; Lecturer, Department of Sociology, Butler University.

confident that he could face his friends and manage on his own.

STRESSING THE CHECK-UP

A closely allied casework service is helping patients to understand the importance of periodic medical check-ups in clinic or in the office of their family physician. It is often difficult for patients to understand why this should be done when they feel so well or have noticed no changes. The trip to clinic is inconvenient and tiring and may seem needless when the doctor's examination takes only a few minutes. Oftentimes the underlying reason for the patient's failure to keep clinic appointments is that "something bad" will be found. The patient must be helped to cope with this fear. Easy to say but not easy to do.

A third casework service is directed toward helping patients with financial and transportation problems. Not infrequently in response to routine inquiries, Tumor Registry receives notes from patients stating that they feel in need of medical care but do not have money to pay for clinic or hospitalization, or have no means of transportation. On the basis of previous medical and social information and the patient's description of the present problem, the social worker and the doctor collaborate in suggesting a plan of action. The social worker suggests the agencies and organizations in the patient's community which are best equipped to help him with his particular problem. The patient then takes the initiative in following these suggestions. On the basis of individual circumstances the social worker may also at this time give interpretation of the patient's needs to the community agency. Through this kind of interest and help, many patients have obtained medical care who otherwise might have delayed too long.

LIAISON IMPORTANT

If the Tumor Registry is to discharge its function of keeping its records up-to-date, it must keep in touch with the patients either directly, through their relatives, or family doctor. Again, in view of this 20th century mobile population, this is not an easy job. Here, after the Registry's attempts to contact the patient in a routine manner have proved unfruitful, is another job for the social worker. Through the social worker's knowledge of community agencies and organizations, the aid of the community is enlisted in locating the patient and his physician and in obtaining from them in a discreet, confidential manner, the necessary information for the Tumor Registry. Recently in this way information was obtained from a patient who had failed to answer inquiries she had received since 1949.

A third category of services rendered by the social worker is termed consultation services to the Tumor Registry staff. Actually the social worker consults with them on all referrals. However, sometimes on the basis of social information which the social worker suggests be handled in a more routine way by the Registry, the social worker does not work with either the patient, his family, or the community. This, of course, does not preclude later action on the part of the social worker and if Tumor Registry is still unsuccessful in finding the answers to its questions, the social worker then attempts to do so through establishing a relationship with the patient or through local agency contacts.

This is the role of the medical social worker. These are the services which she can render to Tumor Registry, its staff and to the patient.

Lake County Cytology Project

WILLIAM H. CORDELL*

Indianapolis

RECENTLY, the American Cancer Society mailed to each of the 190,000 members of the American Medical Association a copy of a brochure entitled "The Physician and the American Cancer Society". In this booklet, the Society not only outlined the work of the A.C.S. on all levels, but also explained how the National Society spent the 40% of the funds which comes to them from the Divisions of the Society.

The 60c out of each dollar left within the state, or Division, is divided in this manner: 40% is retained by the local County Unit, and 20% is kept by the Division for its over-all purposes.

As the Indiana Division and its 92 Units are engaged during this April (Cancer Control Month) in the solicitation of contributions from the general public for the support of its program, I thought it would be of interest to the medical profession to see how one Hoosier Unit has used its 40% of contributions, along with the County Medical Society, in a realistic approach to the problem of cancer control. For this purpose, I asked the officials of our Lake County Unit for permission to reprint the report made by them on the five-year results of its Papanicolaou Cytology Program. This program has been so well-directed and channeled by the medical advisors on the Lake County Cancer Unit Board that it has become increasingly a model for other counties in this state contemplating the development of such a program. The report, as printed below, is excerpted from the report which was submitted early this year by the Indiana Division for consideration by the Committee on Awards of the A.C.S., for possible Citation for Meritorious Unit Achievement in 1956.

The cancer detection program adopted by the Lake County Cancer and Medical Societies aimed at educating the public to seek early diagnosis and prompt treatment to combat the worst effects of cancer. Its sponsors also hoped to render valuable service to the community and to gather facts which might be useful to other cancer fighters.

This was the first use of smear testing on a wide scale to detect early cancer in Indiana. The success of the pioneering project led 15 other areas of the state to adopt similar programs and brought interested inquiries from all parts of the country.

Other accomplishments of the project are still in the future. Physicians are still learning the value of smear testing to find cancer in various parts of the body, giving the test constantly wider application.

Men and women of all ages are now acting voluntarily, seeking the test from their family physicians when no survey is in progress.

Fear of cancer is steadily lessening among the general public, now that quick, positive action to combat it is possible.

Best of all, more Lake County residents appear to be taking the test at earlier ages, thus giving their doctors the best chance to save lives.

Four factors led to launching the Cancer-Medical Society program in Lake County:

—A physician with an interest so great that he personally followed every new report of advances in diagnosis and treatment of cancer.

—A pathologist skilled in the Papanicolaou method of studying cytological smears.

—A young man who lost his wife, mother of three small children, to cancer.

—A Cancer Society executive secretary who

* Acting Executive Director, Indiana Division, American Cancer Society.

wished to put to good use a $10,000 fund piled up by devoted volunteer fund-raisers.

Dr. E. S. Jones, of Hammond, was a member of the Lake County Unit's board of directors when the program was under consideration. He interested Dr. Jean M. Pilot, Hammond pathologist, who already had done some work with cytological study to detect cancer and went to New York to see what Dr. George Papanicolaou was accomplishing at Cornell University Medical College.

Dee O. Coe of Gary, director of radio station WWCA, was president of the county cancer organization shortly after his young wife died of cancer following the birth of their third child. His successor as president, Mrs. Walter K. Paul of Highland, carried out plans for the smear test survey he helped initiate.

Mrs. Verden Glueck of Gary was executive secretary of the recently formed Lake County Unit (organized in 1948). From years of experience in the field of private duty and public health nursing, she felt that money from public donations should, somehow, go back to the donors in the form of real service.

Most important of all, the people of Lake County were ready to face the problem of cancer with action when the opportunity for early detection was presented to them.

To launch the program, members of the medical society first approved it and helped outline its details. The society's executive secretary, John B. Twyman, worked closely with the cancer organization as the survey plans took form.

The Cancer Society distributed samples of printed forms and other equipment needed for the program to all participating doctors, and in addition, publicized the survey plans throughout the county.

Financial support came from several sources, aside from the county's funds, through the efforts of several persons. Rollis S. Weesner, then executive secretary of Indiana Division, presented the project to the state board of directors, which approved return of Lake County contributions made to the state office to develop a worthwhile project. R. Dewey Leever of Gary was instrumental in securing money from Indiana Elks Association's special collection for cancer control and Ray E. Dunn of Gary secured additional support.

In five years these were the results:

Date	Period	Smears	Male	Female	+	?	—	Confirmed
1951	6 mos.	1,428	90	1,338	43	38	1,347	40
1952	4 mos.	965	55	910	20	28	917	18
1953	1 mo.	629	29	600	5	9	615	3
1954	1 mo.	579	13	566	1	7	571	2
1954	1 mo.	457	9	448	2	2	453	2
1955	1 mo.	973	17	956	3	9	961	3
1955	1 mo.	1,017	18	999	6	12	999	4
*Totals		6,048	231	5,817	80	105	5,863	72

* Confirmed positives, in last column, are cases successfully followed up. Some positive and doubtful findings in each series were inevitably "lost" to our follow-up records as patients failed to report for check-up, moved out of the area or were otherwise unrecorded by their physician.

The 18 survivors in the 1951 group, all women, are alive and well in 1956. Most of them are mothers and all are actively pursuing normal lives. Their ages ranged from 28 to 66 with the largest number falling in the 61-70 group. Those in the 31-40 and 51-60 age groups were the next most numerous.

All except one of the 18 were tested by means of vaginal smears. The one exception was a test made from a facial mole.

Fifteen had positive readings on smear tests. The remaining three had doubtful readings.

Radium, x-ray and surgery, or combinations of these, were the treatments used. Ten of the 17 who submitted vaginal smears reported symptoms. The others had the test as a routine examination.

Many gynecologists in the county now perform smear tests for cancer for their patients on a regular schedule, making appointments every six months for this purpose.

A few cases have been received before hospital tissue committees and other medical bodies as classic examples of the value of smear testing for

discovering cancer "in situ" in apparently well persons.

One case was reported as the youngest woman to have panhysterectomy for cancer in that hospital's entire history. The smear test which led to the diagnosis was done on a routine examination in the absence of symptoms.

In 1951, 40 men and women faced a grave problem as smear tests led to a diagnosis of cancer. For 22 of them, the warning came too late. Some were already seriously ill and the test served only to underline what their doctors already knew. They were doomed.

For the 18 who survived, the worst is now past. Five years later, doctors report every single one:

"No symptoms. Prognosis, good".

A.M.A. Plans 'Star-Studded' Convention

PHYSICIANS attending the A.M.A.'s 106th annual meeting in New York City, June 3-7, will find a star-studded revue of exhibits, scientific lectures, medical films, and color television programs lined up for their pleasure and enlightenment. Approximately 18,000 physicians from all over the country are expected to participate in this world-famous "short course" in postgraduate medical education. Focal point of the scientific program will be the Coliseum—New York's new exhibition hall—with four floors devoted to technical and scientific exhibits, many of the scientific meetings, and the color television program. A number of section meetings plus the scientific film program will be held in hotels near the exhibit hall. Headquarters for the House of Delegates will be the Waldorf-Astoria.

An outstanding scientific lecture program is being arranged by the Council on Scientific Assembly. Kicking off the general scientific program on Monday morning, June 3, will be a review of recent progress in surgery, while the afternoon session will deal with recent advances in medicine. Tuesday morning's general meeting will feature a discussion on the use and abuse of mood-altering drugs in daily practice.

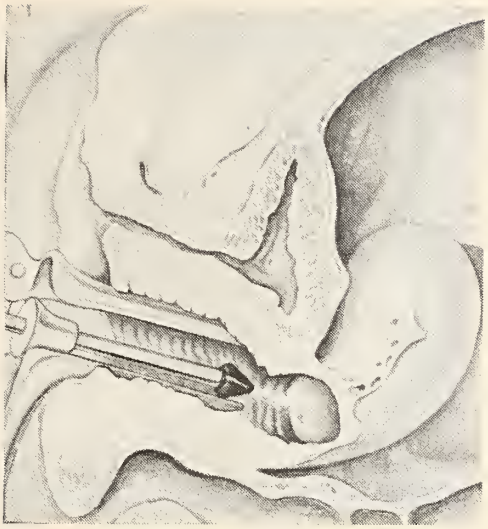
Formal section meetings will run from Tuesday afternoon through Friday morning. Many of the sections will combine to present special symposiums and panel discussions. The Section on Miscellaneous Topics is arranging sessions on allergy, legal medicine—with a mock trial involving the testing of drinking drivers, and methods of improving communication in medicine. A number of exhibit-symposiums and question-and-answer conferences also will be held. Special exhibits on fractures, diabetes, perinatal mortality, pulmonary function testing, fresh tissue pathology, arthritis, and nutrition also will be presented.

The color television program presenting live surgical procedures from Roosevelt Hospital will again be sponsored in cooperation with Smith, Kline & French Laboratories.

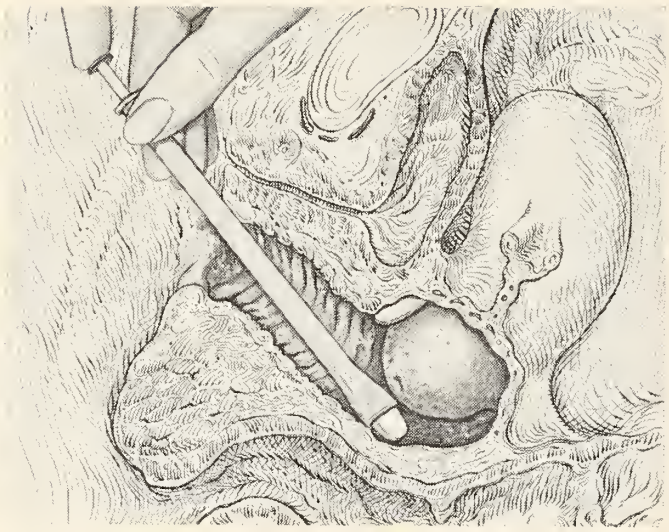
A foreign air is being added to the regular medical film program for the first time. More than 20 foreign countries are sending special films, dealing with many aspects of medical science, to the "international medical film program." Both the international and regular film programs will be held at the Barbizon Plaza Hotel.

Registration officially opens at the Coliseum Monday at 8:30 a.m. and closes Friday noon. Advance registrations will be accepted Sunday from 12 noon to 4:00 p.m. The exhibit hall will be open to doctors only on Tuesday and Wednesday mornings to give physicians an opportunity to circulate more freely among the technical and scientific exhibits. The new Coliseum has many facilities, including air conditioning, escalators, elevators, a cafeteria, and snack bars.

COMPREHENSIVE VAGINITIS REGIMEN



Powder Insufflation



Tablet Insertion

Floraquin® Rebuilds the Defense Mechanism in Vaginitis

Combined office and home treatment with Floraquin provides a comprehensive regimen which encourages restoration of the normal "acid barrier" to pathogenic infection.

Vaginal secretions normally show a high degree of protective acidity (pH 3.8 to 4.4). When this "acid barrier" is disturbed, growth of benign Döderlein bacilli is inhibited and that of pathogens encouraged. Floraquin not only provides an effective protozoacide and fungicide (Diodoquin®) destructive to pathogenic trichomonads and yeast, but also furnishes sugar and boric acid for reestablishment of the normal vaginal acidity and regrowth of the normal protective flora.

Suggested Office Floraquin Insufflation

". . . the vagina is treated daily by swabbing with green soap and water, drying and insufflation of Floraquin powder."*

Suggested Home Floraquin Treatment

"The patient is also issued a prescription for Floraquin vaginal suppositories which she is instructed to insert high into the vagina each evening. On the morning following each application of these suppositories, the patient should take a vinegar water douche. . . ."*

A Floraquin applicator is supplied with each box of 50 Floraquin tablets. G. D. Searle & Co., Chicago 80, Illinois, Research in the Service of Medicine.

*Williamson, P.: Trichomonad Infestation, M. Times *84*:929 (Sept.) 1956.

SEARLE

Doctors as Insurance Salesmen

A. L. MARSHALL, JR., M.D.

Indianapolis

INTRODUCTION

A TOTAL OF 15,400 CASES of poliomyelitis in 1956 were reported nationally for a case rate of 9.2 per 100,000 population for the United States. Indiana followed the national trend with 405 cases reported, for a case rate of 9.3 per 100,000 population. This is the lowest rate reported in Indiana since 1951. The highest case rate ever reported in Indiana was 40 per 100,000 in 1952. The wide annual variations in the incidence of polio prevent any positive conclusions that the low incidence in 1956 was due to the widespread but nevertheless inadequate use of polio vaccine.

AGE DISTRIBUTION OF CASES

In Table I a comparison can be made between the marked annual variations in the reported number of cases and the per cent of cases in each age group for the periods shown. In Table I it is seen that in 1954 and 1955 the per cent of cases for age groups 5-10 and 11-15 decreased; the per cent of cases 1-4 and over 21 increased; while the age groups under one year and 16-21 years remained about the same as the previous three years experience. These changes are somewhat significant in the light of vaccine administration. The vaccine field trials of 1954, the school vaccine program of 1955, and the first distribution of allocated and commercial vaccine were aimed at the age group 5-10 years. It appears that vaccine use, even though limited, has decreased the occurrence of polio in this highly susceptible group. As vaccine became more plentiful, other age groups were included, but not to a great degree. I believe the drop in the 11-15 age group is largely due to children immunized in 1954 and 1955 now comprising a large segment of this group. The continued administration of vaccine to children of grade school age, without protecting other groups, would continue the changes in age susceptibility, so that most cases would occur before age 4 years or after 21. Mass immunization of school children is not the entire solution to the problem of community protection against poliomyelitis.

The fact that no change was noted in the per cent of cases occurring under the age of 1 year is disappointing. Immunization of all expectant

TABLE 1. Polio Cases and Percentages by Age Groups 1952-1956

	1952			1953			1954			1955			1956		
	Cases	Percentage		Cases	Percentage		Cases	Percentage		Cases	Percentage		Cases	Percentage	
To 1 year	33	2.07		6	9.96		24	2.84		9	2.01		13	3.2	
1- 4	428	26.75	72.23	136	21.92	66.24	193	22.89	73.62	112	25.1	70.91	124	30.61	67.65
5-10	486	30.53		184	29.44		293	34.73		118	26.4		100	24.69	
11-15	203	12.11		87	13.92		111	13.16		78	17.4		37	9.13	
16-21	144	9.04		62	9.92		65	7.71		32	7.17		31	7.65	
Over 21	263	16.52		138	22.08		143	16.96		85	19.05		100	24.69	
Unknown	35	2.19		12	1.92		17	2.01		12	2.69		0		
TOTALS	1,592			625			843			446			405		

mothers and immunization of babies at 6 months of age should eliminate cases in this group.

TABLE 2
Vaccinated vs. Unvaccinated Cases

Type	No. of Cases	No Vaccine	Vaccine
Paralytic	230	202	28
Non-paralytic	169	141	28
Unspecified	6	5	1
	Total 405	348	57

TABLE 3
Cases Reported Who Had Had Vaccine

	One Dose	Two Doses	Three Doses
Paralytic: 28	15 (six within one week of inoculation; nine, two weeks to one year later)	11	2*
Non-paralytic: 28	7 (five within one month of inoculation; two, 3-5 months)	14	7

Note: One case unspecified polio, number of injections of vaccine unknown, is under investigation at present time.

* One case reported as polio death. Circumstances unusual in that child was ill for 24 hours before physician was called. Physician ordered child to hospital. The child died 30 minutes after admission. No laboratory or autopsy confirmation.

Paralysis in the 28 cases of paralytic polio that had vaccine is reported to be moderate or mild.

LABORATORY

Confirmation of the diagnosis of polio on the 57 cases receiving vaccine cannot be analyzed at present because all specimens have not been examined by the laboratory. In addition, stool and blood specimens were not received on all vaccine cases.

MORTALITY

Twenty-two of 405 cases terminated fatally for a mortality of 5.4 per cent. There were nine of the 22 cases, 7 months of age to 18 years of age. Thirteen of the deaths occurred 21 to 44 years of age.

ADULTS

There were 118 cases of polio reported age 18 to 42 years. Investigation revealed 96 of these individuals were married; 39 had children; and there were three families where one child in the home had polio at the same time as the parent.

SUMMARY

(1). Low incidence of poliomyelitis in 1956 is encouraging in the light of vaccine usage, but not conclusive.

(2). Significant decrease in the percentage of cases in the 5-10 and 11-15 age groups may well be indicative of beneficial effect of vaccine.

(3). 75.28 per cent of reported cases occurred under age 21 years, but 59 per cent of deaths occurred over age 21 years. Therefore, polio still remains "infantile paralysis", but like measles, mumps, and other childhood diseases, is more severe when contracted during adult life.

(4). 81.3 per cent of adult cases were married individuals and 37½ per cent of these individuals had children. This is important to keep in mind, as polio again follows the general pattern of other childhood diseases. The young married adult is exposed to infection by subclinical or inapparent infection of his own children or children of friends.

EPILOGUE

The most precious possession to be had is good health, but it is prized by few. Certainly, every parent should protect his children against polio. Economic hardship may be a barrier or a cause of dereliction of some parents in having children immunized. The procrastination of the majority, however, is not accountable for on the basis of economics, but rather a complacency that "it can't happen to me or mine." It is true that the odds are in the gambler's favor; but unlike gambling with things of monetary value, if you should lose in this venture, you have lost something that can never be rewon. In the case of the parent, the stakes to be lost become immeasurable —just picture the average family in which polio may strike. Discounting the emotional trauma to a family seeing one of its members suffering, perhaps dying or being crippled for life, and you yet have to reckon the economic blow to a family from hospital and medical expenses. No one can say he is immune to the disease, but only that

Fifty Years Ago . . .

COMPLETE BOUND VOLUMES of THE JOURNAL of the Indiana State Medical Association from the first issue in January 1908 to the present time are now in THE JOURNAL's possession, thanks to Mrs. Merle Stemm Brown, daughter of the late Dr. William H. Stemm of North Vernon. Dr. Stemm's bound volume of the first year's issues has been presented to us together with several other interesting books and photographs. We are grateful for this generous and thoughtful gift. Through some accident no copy of the March 1908 issue was saved for binding by the first staff of THE JOURNAL. That is included in our recently acquired volume.

That issue 50 years ago said this in an original article by Dr. Albert M. Cole, professor of electrotherapeutics and radiology at the Medical College of Indiana: "The value of radiotherapy in superficial cancer and many skin diseases is well attested by many observers, but that the x-ray possesses decidedly curative action in certain diseased conditions below the skin is not so widely known. . . . Today no reputable authorities make any claim to cure cancer below the skin with the x-ray, although in rare cases they have disappeared under its use; but as a palliative and to prevent a recurrence after operation, Roentgenization should be advised."

. . . and these sage remarks appeared in an article called "Practical Notes from a General Practitioner of Medicine": "Patients will always take medicine when they will not take advice . . . the physician whose force of character makes his advice sought after and followed is the one who accomplishes the most good" . . . and later Dr. George Rowland of Covington wrote: "The rapid progress of civilization and of human knowledge will soon bring the future physician to the point where his chief duty will be not to treat disease but to point out how it may be prevented."

Michigan and California medical journals sent congratulations to Indiana physicians on their new publication and California said: ". . . and not the least pleasant thing to note in regard to the newly-born journal is the statement that it will advertise no preparations other than those of the Pharmacopeia, the National Formulary, and such as have been approved by the Council on Pharmacy and Chemistry of the American Medical Association . . . 'individual judgment' is not worth a rap when one is dealing with a bunch of liars, and of all liars the nostrum man is king . . ."

History repeats itself . . . the first editorial concerned a plea for the assistance of the county society secretary and said in part: ". . . We fully explained that it was our intention and desire to make THE JOURNAL of particular interest to every physician in each county in the state, but that our efforts in this direction would not meet with the best success unless we could have the cordial and willing assistance of the county secretaries to whom we are rightfully entitled to appeal for cooperation . . . to be of most service THE JOURNAL must be the organ of all the physicians, and as such we must report the proceedings of the various county societies and information of interest regarding the members of those societies."

Other editorial comment . . . "The time has come when 'the commission man in medicine' no longer merits the protection of honest practitioners of medicine, and the quickest and surest way of remedying the evil is by publicity."

"Personals" dealt largely with illness of members and their sojourns to warmer climates for rest . . . mention was made of "sciatica, mumps, and bronchial asthma."

A $50,000 donation from John D. Rockefeller to the new Indiana University School of Medicine at Indianapolis was reported. . . . Charles City, Iowa physicians established a fee schedule and several individual doctors had been indicted on the charge of attempting to fix, regulate and maintain prices . . . and a suburb of Paris (France, that is) set fees according to ability to pay . . . a call on a laborer was 60 cents; on a small merchant or clerk, 80 cents; and on a large manufacturer, merchant or wealthy landowner, $1.00.

Reports of Society Proceedings reveal the healthy activity and interest at the county level . . . the case report was the popular feature of many meetings, clinics were held with members observing surgical procedures, and out-of-state speakers brought the newest developments in medicine to even the smallest county groups.

Men of medicine in Indiana 50 years ago were untiring in their search for the new in treatment and in prevention of disease. They were untiring, too, in their efforts to pass on the benefit of this knowledge to their patients. The saga of the horse-and-buggy doctor has been told many times but is always new—the acceptance of the automobile as a satisfactory mode of transportation was not complete in 1908 in all parts of Indiana—and so as the year rolled on old Dobbin played a leading part in helping to improve the health of the citizens of the state.

—J.S.G.

In civil defense, a steady siren wail for three to five minutes is an alert signal. It means you should turn your radio to 640 or 1240 kilocycles for emergency instructions. A series of short siren blasts totaling three minutes means to take cover.

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For the Asthmatic

Fast Relief

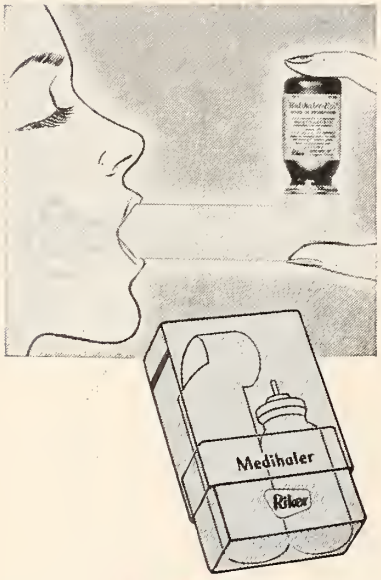
Medihaler offers virtually instantaneous relief and does so with little effort and with maximum safety.

Measured-Dose True Nebulization

Delivers a measured dose of true nebular vapor...Dose is always the same regardless of strength of fingers or amount of medication in bottle.

Costs the Patient Less

Medihaler Oral Adapter is made of unbreakable plastic ...no moving parts...and 200 applications in each 10 cc. bottle.



Medihaler-Epi®

Riker brand of epinephrine U.S.P. 0.5% solution in inert, nontoxic aerosol vehicle. Each ejection delivers 0.125 mg. epinephrine. In 10 cc. vial with metered-dose valve.

Indicated in acute or recurring bronchospasm. Replaces injected epinephrine in many emergency situations.

Medihaler-Iso®

Riker brand of isoproterenol HCl 0.25% solution in inert, nontoxic aerosol vehicle. Each ejection delivers 0.06 mg. isoproterenol. In 10 cc. vial with metered-dose valve. • Indicated in acute or recurring bronchospasm.

Note: *First prescription should include desired medication and Medihaler Oral Adapter, supplied with pocket-sized plastic container.*

The Medihaler principle

is also available in Medihaler-Nitro™ (octyl nitrite) for the rapid relief of angina pectoris...and Medihaler-Phen™ (phenylephrine-hydrocortisone-neomycin) for lasting, effective relief of nasal congestion.

Riker LOS ANGELES

The Woman's Auxiliary

REPORTS TO I.S.M.A.

The State Rural Health Committee of the Woman's Auxiliary has been working hard to promote some type of Health Day Program in local communities. The goal was set for 10 meetings, and we are nearing our goal. Three were held in November, at Lafayette, Crown Point and Seymour, one in February at Bremen, and four Health Days were held in March at Rushville, Nashville, Logansport and Marion. New Castle is completing plans for one in April, New Albany and Tell City have tentative plans for late Spring, and Elkhart plans an early Fall program.

These meetings are a free community service organized by the local Auxiliaries, with the permission and assistance of the local medical societies. The Auxiliaries organize the details, such as securing the date and place, having the programs printed, contacting the newspaper editor for good publicity, and assigning topics which they desire to the doctors. Better medical public relations stem from such a service.

The State Rural Health chairman, Mrs. Paul Sparks of Winchester, has master-minded a hard-working committee which was divided into four groups with a sub-chairman for each, namely: Mrs. Burton Kintner, Elkhart; Mrs. Forrest Babb, Lafayette; Mrs. Kenneth Schneider, Nashville, and Mrs. Lewis Lohoff, Tell City.

Each committee chairman arranged area meetings to explain to the county chairmen in her area how to set up such a meeting. I wish to thank this efficient committee for their cooperation and effort.

Mrs. Paul Sparks
Winchester
Chairman, Rural Health

Mrs. Paul Sparks, state chairman, says:

"Our purpose is to assist the Indiana State Medical Association to promote positive health education in all communities.

"Our goal is to help plan and carry out a HEALTH DAY, EVENING FORUM, or a series of health programs in as many counties throughout the state as possible."

YOUR STATE RURAL HEALTH COMMITTEE

North East Area Chairman
Mrs. Burton Kintner
3520 E. Jackson, Elkhart

North West Area Chairman
Mrs. Forrest Babb
2106 S. 9th St., Lafayette

South East Area Chairman
Mrs. Kenneth Schneider
Nashville

South West Area Chairman
Mrs. Lewis Lohoff
425 N. 10th St., Tell City

Mrs. Kintner plans a Health Day Program for Elkhart County in the Fall; Mrs. Babb supervised a November 8 program at the Tippecanoe County Fairgrounds (the program is included in this report); Mrs. Schneider's program was scheduled for March 18, in the Methodist church in Nashville; and Mrs. Lohoff, who is Perry County Auxiliary president, has scheduled a Health Day for Tell City in May.

Mrs. Kenneth Hill
New Castle

Mrs. Lowell Hillis
Logansport

Mrs. James C. Miller
Greensburg

Mrs. Nelson Wolfe
New Albany

Mrs. Hill has planned a Henry County Health Day for April 10, in the New Castle High School gymnasium; Mrs. Hillis, Cass County president, presented a March 20 Health Day in the National Guard Armory at Logansport.

Plans are nearing completion for two other Health Day programs. Mrs. Miller, Decatur County Auxiliary president, will supervise an April program in Greensburg, and Mrs. Nelson Wolfe, New Albany, has scheduled a late Spring program for Floyd county.

SUCCESSFULLY PRESENTED

Health Day—November 8, 1956
Sponsored by Tippecanoe County Medical Society and Woman's Auxiliary to the Medical Society
Tippecanoe County Fairgrounds

1:00 P. M. Pediatrics Panel
H. B. McAdams, M.D.—Use of Antibiotics
R. E. Miller, M.D.—Rheumatic Fever
J. Burns, M.D.—The Handling of Illness and Emergencies in the Home
D. M. Jones, M.D.—Is This Shot Necessary?

2:00 P. M. Diseases of Ageing
R. P. Gripe, M.D.—Heart Disease
R. A. Flack, M.D.—Diabetes
R. Bolin, M.D.—Cancer
B. Klatch, M.D.—Mental Health

3:00 P. M. Auto Safety—State Police Trooper C. R. Allenduff, Safety Education Officer

3:00 P. M. Home Safety
R. E. Williams, M.D.—Home Accidents and Their Preventions

4:00 P. M. Film

4:15 P. M. Nurses—The Nurse in Your Community

4:30 P. M. Growth of Medicine in Lafayette—F. W. Peyton, M.D.

INTERMISSION

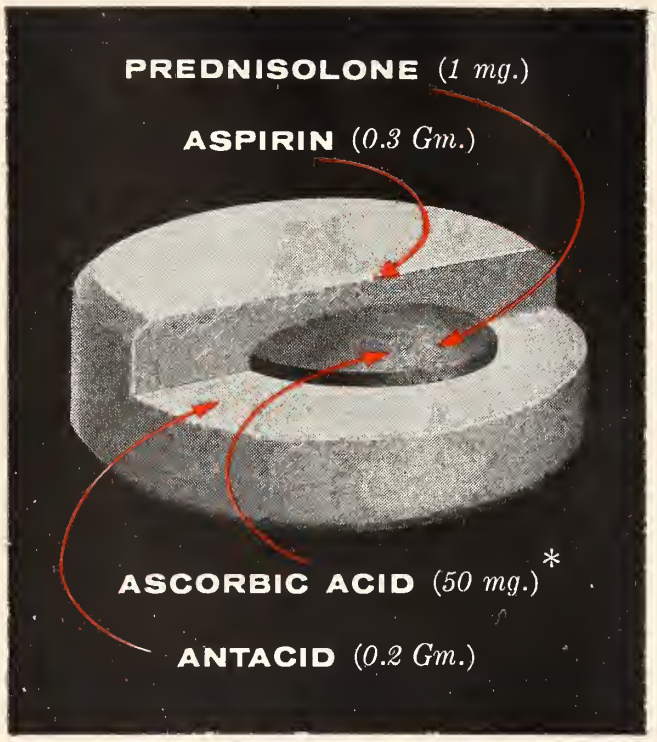
6:00 to 8:00 P. M. Partial Repeat of Afternoon Program

"The Ounce of Prevention"
November 8, Indian Trail Grange Hall
Sponsored by the Lake County Medical Society and the Woman's Auxiliary

1:00-2:30 P. M. Childhood Diseases and School Health.
Moderator: Mr. Dee Coe, Manager of radio station WWCA, Gary.
Speakers: Dr. W. A. Misch, Cedar Lake.
Dr. Donald J. Faulkner, Hobart.

Please turn to page 472

Mrs. Julius Klaus
Crown Point
Chairman



Proper formula for treating "Rheumatism" patients

Multiple Compressed Tablets

TEMPOGEN®

With TEMPOGEN, many patients obtain adequate relief from immobilizing "rheumatic" pain with lower hormone dosages than are ordinarily required, because of the enhanced antirheumatic effect provided by the prednisolone-salicylate combination. In addition, the likelihood of the occurrence of gastric distress or adrenal ascorbic acid depletion is minimized.

INDICATIONS: Early rheumatoid arthritis, rheumatoid spondylitis, osteoarthritis, Still's disease, psoriatic arthritis, bursitis, synovitis, tenosynovitis, myositis, fibrositis, and neuritis.

Supplied: TEMPOGEN® and TEMPOGEN® Forte—in bottles of 100 Multiple Compressed Tablets. (TEMPOGEN Forte provides 2 mg. of prednisolone.) TEMPOGEN and TEMPOGEN Forte are trademarks of Merck & Co., Inc.

**present as 60 mg. sodium ascorbate*

MSD

MERCK SHARP & DOHME

DIVISION OF MERCK & CO., INC. PHILADELPHIA 1, PA.

Miss Mamie Spangler, Lake County Supervisor of Elementary Education.
Mrs. Sidney Barnacastle, Crown Point School Nurse.

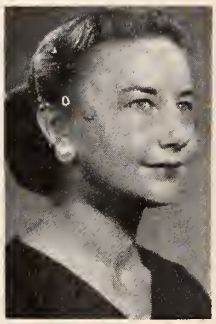
7:00-8:30 P. M. Farm and Highway Accidents.
Moderator: Mr. W. C. Struebig, Secretary, Lake County Farm Safety Council.
Speakers: Highway Accidents.
Dr. J. M. Klaus—First Aid in Accident Cases.
Mr. Albert Hartman, Safety Education Director for 1st District of Indiana State Police.
Farm Accidents:
Mr. James Wehrly, Assistant County Agent.

9:00 P. M. Could South Lake County Have a Hospital?
Moderator: Dr. Robert G. Husted, Hammond, President Lake County Medical Society.
Speakers: Dr. John Birdzell, Crown Point.
Dr. William Troutwine, Crown Point.
Dr. David Templin, Lowell.

"Your Doctor Speaks Out"
November 14—First Baptist Church, Seymour
Sponsored by Jackson-Jennings County
Woman's Auxiliary

9:00 A. M.	Welcome	W. D. Scharbrough, M.D., Medora
9:30 A. M.	Heart Panel	Walter S. Fisher, M.D., Columbus Harry R. Baxter, M.D., Seymour Ralph O. Bosch, M.D., Seymour
	Moderator: John W. Ripley, M.D., Seymour	
10:30 A. M.	Cancer Panel	Howard Rothring, M.D., Columbus C. A. Wiethoff, M.D., Seymour W. D. Day, M.D., Seymour W. H. Shortridge, M.D., Seymour
	Moderator: Jack E. Shields, M.D., Brownstown	
12 Noon	(Recess)	
1:00 P. M.	T. B. Panel	Warren Tucker, M.D., Indianapolis William Johnson, M.D., North Vernon Joe Butler, M.D., Crothersville
	Moderator: John Green, M.D., North Vernon	
2:00 P. M.	Ounce of Prevention Panel	B. W. Thayer, M.D., North Vernon K. E. Bobb, M.D., Seymour H. E. Miller, M.D., Seymour F. B. Bard, M.D., Crothersville
	Moderator: G. R. Gillespie, M.D., Brownstown	
3:00 P. M.	Farm Accident Prevention Panel	B. W. Mathews, M.D., North Vernon H. P. Graessle, M.D., Seymour Guy Martin, M.D., Seymour
	Moderator: J. M. Black, M.D., Seymour	
4:00 P. M.	Adjournment	

"Health Is Our Greatest Heritage"
February 5, 1957—Bremen
Sponsored by Marshall County Woman's Auxiliary


Mrs. James Robertson
Plymouth
Chairman

A Health Fair carrying out the theme "Health Is Our Greatest Heritage" was held from 9 a.m. to 4 p.m. Visitors to the Health Fair received literature secured from the National Safety Council and the Heart Foundation, the Polio Foundation, Blue Cross-Blue Shield, and Today's Health.

Eye-catching posters on various health subjects were used at the booth on Health. The booth is being offered to groups of over 50 for their meetings.

Coffee was served throughout the day to promote friendly relations.

The painting of "The Doctor" by Fildes was displayed with the following inscription from the film "Even for One":

"When you call me to your side, you are buying what it has taken me all my life and training to learn . . . you are buying my skill, my art, perhaps . . . but, most of all my judgment."

Mrs. Kenneth Corpe
Rushville
Chairman

Rush County Health Day
March 12, 1957—Gregg School, Rushville
Sponsored by Rush County Medical Society and Woman's Auxiliary

9:45-10:00	Welcome	Mr. Bernard McKenzie
10:00-11:00	An Ounce of Prevention	Moderator—Dr. Frank H. Green
	Detection by X-Ray	Dr. Clement L. Poston
	Salk Vaccine	Dr. Melvin H. Denny
	Tetanus Immunization	Dr. Davis W. Ellis
	Why an Annual Physical Exam.	Dr. Joseph Walther
11:00-12:00	General Panel	Moderator—Dr. Marvin G. Norris
	Obesity	Dr. Robert B. Johnson
	Early Detection of Cancer	Dr. Kenneth F. Corpe
	Heart Disease	Dr. Joseph Walther
	Arthritis	Dr. Willard Worth
12:00- 1:00	Intermission for Lunch	
	Welcome	Mrs. William R. Tindall
1:00- 1:30	Film "Horror on the Highway"	Sgt. Edwin Schwendenmann
1:30- 2:30	How to Have a Healthy Child	Moderator—Dr. Charles E. Sheets
	Communicable Diseases	Dr. Frank H. Green
	Allergies and the Common Cold	Dr. Clarence C. Atkins
	Ear, Nose, and Throat	Dr. Donald I. Dean
	Rheumatic Fever	Dr. Richard M. Nay
2:30- 3:30	Mental Health	Moderator—Dr. George B. McNabb
	In the Child	Dr. Wyndham H. Nutter
	Anxiety in the Adolescent	Dr. Richard C. McNabb
	In Middle Age	Dr. Harry G. McKee
	How to Grow Old Gracefully	Dr. Richard M. Nay

Health Day Conference
March 20, 1957—Grant County 4-H Building, Marion
Sponsored by Grant County Medical Society and Woman's Auxiliary

1:15 p. m.	Welcome and introductory remarks—Mrs. E. S. Rifner, Mrs. William Tindall, E. S. Rifner, M.D.
1:30 p. m.	OBSTETRICS—Moderator, Max Long, M.D.
1:40 p. m.	Pre-natal Care—C. B. Warren, M.D.
1:50 p.m.	Anesthesia During Childbirth—M. A. Grant, M.D.
2:00 p. m.	Emergencies in the Expectant Mother—J. C. Jarrett, M.D.

Mrs. E. S. Rifner
Van Buren
Chairman

2:10 p. m.	Post-natal Care—R. G. Young, M.D.
2:20 p.m.	Summary by the moderator and questions from the floor.
2:30 p. m.	"Unconditional Surrender" film on Salk vaccine.
3:00 p. m.	PEDIATRICS—R. S. Lahr, M.D., Moderator.
3:10 p. m.	Immunization—R. W. Schroder, M.D.
3:20 p. m.	Tonsils—L. L. Renbarger, M.D.
3:30 p. m.	Prevention of Heart Damage in Children—Edna Wojcik, M.D.
3:40 p. m.	Surgery in Children—W. W. Ayres, M.D.
3:50 p. m:	Summary by the Moderator.
4:00 p. m.	NUTRITION—Moderator, A. Ward Bloom, M.D.
4:10 p. m.	Vitamins—Dr. Stephen Ansbacher.
4:20 p. m.	Food and Your Heart—R. M. Hummel, M.D.
4:30 p. m.	Food and Your Blood—L. V. Love, M.D.
4:40 p. m.	Nutrition and Allergy—Robert Cunningham, M.D.
4:50 p. m.	Summary by the Moderator.
	Supper will be available in the building.
	"That They May Have Life" a film on Riley Hospital will be shown several times during the supper hour.
	Time to examine the displays of your Health Agencies.
7:00 p. m.	Movie and Lecture on Highway Safety—Sgt. Paul Doherty of State Police Dept.
7:30 p. m.	HEALTH HAZARDS in MODERN LIVING—Moderator, Joe Davis, M.D.
7:40 p. m.	Injuries Upon Injuries—Leo Diamond, M.D.
7:50 p. m.	Mistreatment of Burns—J. P. Powell, M.D.
8:00 p. m.	First Aid to Fractures—C. F. Abel, M.D.
8:10 p. m.	Farm and Home Injuries—Merrill Davis, M.D.
8:20 p. m.	Summary by the Moderator.
8:30 p. m.	AN OUNCE OF PREVENTION—Moderator, Wm. A. Koontz, M.D.
8:40 p. m.	Eye—A. B. Snowhite, M.D.
8:50 p. m.	Detection by X-ray—Wm. Comeau, M.D.
9:00 p. m.	Prevention of Heart Damage—Henry Alderfer, M.D.
9:10 p. m.	How to Contact Your Doctor—J. G. Rohrer, M.D.
9:20 p. m.	Summary by the Moderator.

Don't forget our annual House of Delegates meeting April 24-26 in Richmond! For full details about the convention see page 477.

Julia Tindall

MRS. WILLIAM R. TINDALL, *President*

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Outstanding Convention Planned by Woman's Auxiliary for April 24-26

MRS. WILLIAM R. TINDALL*

Shelbyville

OUR HOUSE OF DELEGATES of the Woman's Auxiliary to the Indiana State Medical Association will hold the 29th annual convention in Richmond, April 24, 25 and 26, at the Leland Hotel.

The members of Wayne-Union County Auxiliary will serve as hostesses. Working with the state officers they have planned what they hope will be the biggest and best convention in Auxiliary history.

Our National President, Mrs. Robert Flanders of Manchester, New Hampshire, will be with us and every Indiana physician's wife will want to meet her and hear her speak. Doctors are urged to help their wives arrange to attend and get acquainted with other doctors' wives from over the state.

Dr. Elton Trueblood, professor of philosophy at Earlham College, Richmond, will be the Thursday evening banquet speaker in the Ball Room of the Leland Hotel. Mrs. Flanders, the National Auxiliary President, will be the speaker at the luncheon Thursday noon in the Richmond Country Club.

Mrs. Morris Wertenberger is general chairman for the convention and is being assisted by Mrs. Glen Ward Lee, Mrs. John Ling and Mrs. Leslie Laird, all of Richmond. Mrs. Elwood Meredith is president of Wayne-Union County Auxiliary.

Headquarters for the convention is the Leland Hotel, Richmond; the dates are Wednesday evening, April 24 through Friday noon, April 26. A Hospitality Room will be open at all times on the mezzanine floor of the hotel where members and guests may meet.

Highlights of the program follow:

Wednesday Evening, April 24

Registration ---------- Mezzanine, Leland Hotel (2-6 p.m.)
Get Acquainted Buffet ---------- Tudor Room, Leland Hotel (6:30-8 p.m.)

Thursday, April 25

Continental Breakfast ---------- Mezzanine, Leland Hotel (8-9 a.m.)
Opening Session ---------- Parlor A, Leland Hotel (9:30 a.m.-12 noon)
Luncheon ---------- Forest Hills Country Club (1 p.m.)
(Busses will take members from Leland Hotel to Country Club)
Business Meeting continued ---------- Country Club
Banquet ---------- Ball Room, Leland Hotel (6:30 p.m.)
Reception for National President ---------- Tudor Room (9-10 p.m.)

Friday, April 26

Memorial Breakfast ---------- Ball Room (8:30-9:30 a.m.)
Election of Officers ---------- Parlor A (11 a.m.)
Luncheon ---------- Ball Room (12:30-2:30 p.m.)

* President of the Woman's Auxiliary, Indiana State Medical Association.

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Industrial Health Conference Scheduled for St. Louis

More than 200 of the country's leading specialists in the complexities and technicalities of preventive medicine and hygiene in industry will speak at the Twelfth National Industrial Health Conference in Kiel Auditorium, St. Louis, April 20-26.

The conference annually brings together five organizations responsible for maintaining the health of the nation's industrial workers: the Industrial Medical Association, American Industrial Hygiene Association, the American Association of Industrial Nurses, the American Conference of Governmental Industrial Hygienists, and the American Association of Industrial Dentists.

All persons in the field of industrial health, representatives of management and physicians in general practice who have industrial affiliations are invited to attend. The complete program may be obtained from Dr. E. C. Holmblad, Managing Director, Industrial Medical Association, 28 East Jackson Boulevard, Chicago 4, Illinois.

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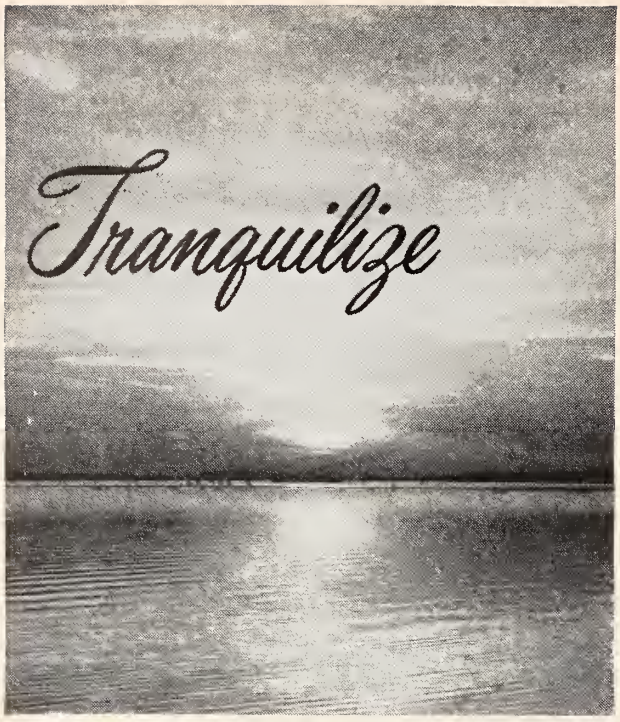

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Army's First Interns to Report to Class I Hospitals in July

Fourteen June graduates of medical schools approved by the American Medical Association will report for duty at the U. S. Army Hospital, Fort Benning, Ga., July 1, 1957, to inaugurate the first internships yet instituted for the Army's Class I hospitals.

This will be a "pilot" program directed towards the introduction of such training in other hospitals of this classification.

Col. Byron L. Steger, MC, Chief of the Education and Training Division, Office of The Surgeon General of the Army and Capt. F. Talmadge Powell, his administrative officer, left March 5, for the 3rd Army area to hold a series of hospital conferences on graduate professional education which will include Fort Benning.

Extension of the intern program of the Army Medical Service to other Class I hospitals is hoped for as a result of the pilot study. Applications for Army medical internships have exceeded by far in recent years the number of openings available at the Army's named teaching hospitals. This has brought about a need to expand the intern training programs to accommodate more of the young physicians interested in Army professional training.

A total of 150 medical school graduates are now admitted to the established intern training programs at the Army's named teaching hospitals but for current training years, many more than this number of applications, have been received by The Surgeon General.

Army educational authorities indicate that the conduct of an intern training program helps improve the quality of patient care at the hospitals concerned.

Two schoolboys long ago took a dislike to each other, and the hatred grew more intense as the years passed. One entered the Navy and finally became an admiral. The other went into the church and eventually was made a bishop. Years later they met on a London railway station platform. They had changed, of course, and the bishop had grown very plump, but they recognized each other. The bishop walked up to the admiral, standing there resplendent in his uniform with medals and gold braid glittering all over him, and said: "Stationmaster, when does the next train leave for Oxford?"

The admiral batted not an eye as he responded: "In half an hour, madam. But in your condition, should you be traveling?"

Dexamyl* (a combination of dextro-amphetamine sulfate, S.K.F., and amobarbital) induces a mood of cheerfulness and optimism. Often, this is all that is needed to help the aged overcome their loneliness, the resentful feeling of being unwanted, the fears (imagined or real) of physical failings.

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COOK COUNTY GRADUATE SCHOOL OF MEDICINE

INTENSIVE POSTGRADUATE COURSES

STARTING DATES — SPRING, 1957

SURGERY—
Surgical Technic, Two Weeks, April 29, May 13
Surgery of Colon & Rectum, One Week, May 6
General Surgery, Two Weeks, May 6, One Week, May 13
Surgical Anatomy & Clinical Surgery, Two Weeks, June 17
Thoracic Surgery, One Week, June 10
Esophageal Surgery, One Week, June 17
Breast & Thyroid Surgery, One Week, June 17
Gallbladder Surgery, Three Days, June 24
Surgery of Hernia, Three Days, June 27
Fractures & Traumatic Surgery, Two Weeks, June 17

GYNECOLOGY & OBSTETRICS—
Office & Operative Gynecology, Two Weeks, June 17
Vaginal Approach to Pelvic Surgery, One Week, June 10
General & Surgical Obstetrics, Two Weeks, May 6

MEDICINE—
General Review Course, Two Weeks, April 29
Electrocardiography & Heart Disease, Two-Week Basic Course, July 8
Hematology, One Week, June 17

RADIOLOGY—
Diagnostic X-Ray, Two Weeks, April 29
Clinical Uses of Radioisotopes, Two Weeks, May 6

CYSTOSCOPY—
Ten Day Practical Course by appointment

PEDIATRICS—
Two-Week General Course, May 13
Neuromuscular Diseases, Two Weeks, July 8

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Educational Film for Diabetics Produced by Ames

The film "Urine Sugar Analysis for Diabetics," developed in cooperation with the medical profession, is now available at no charge to the medical and allied professions through Ames Company, Inc., Elkhart, Indiana, or from an Ames representative.

The film was made as a visual aid to be used in the education of diabetic patients and shows the relationship between carbohydrates and insulin. It also explains in lay language the meaning of various diabetic conditions. It has been produced on 16 mm. film in color and sound track with a running time of approximately 10 minutes. Literature accompanies the film.

Showings at Diabetic Clinics, Diabetic Lay Societies and other groups must be requested by the medical or allied professions.

The six ages of man: beef broth, ground steak, sirloin, filet mignon, ground steak, beef broth.

Outguessing your "Second Guessers" ...always a serious problem in OBESITY!

It's easy with DIOCURB!

This New Dosage form of dextro amphetamine sulfate is *not readily recognizable* by the most astute patient!

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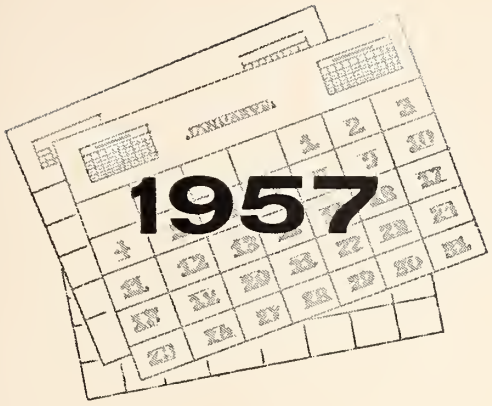

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Philadelphia Award Given Dr. Ravdin, Former Hoosier

Dr. Isador Ravdin, native of Evansville and now a leading Philadelphia surgeon, recently received the annual Philadelphia Award established in 1921 by Edward Bok. The award consists of $10,000 and a bronze medal and is given to the person living in the Philadelphia area who "during the preceding year . . . has contributed a service calculated to advance the largest interest of the community." Dr. Ravdin is chief surgeon at the University of Pennsylvania Hospital and professor of surgery at the university's medical school. He was honored for his service to the advancement of scientific research and for his personal integrity.

Dr. Ravdin is a brother of Dr. Bernard D. Ravdin, Evansville, and son of the late Dr. Marcus Ravdin.

He received national publicity last year when he was a member of the team of specialists performing an ileitis operation on President Eisenhower.

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New mint-flavored Sigmamycin for Oral Suspension, 1.5 Gm. in 2 oz. bottle; each 5 cc. teaspoonful contains 125 mg. (oleandomycin 42 mg., tetracycline 83 mg.). *Trademark

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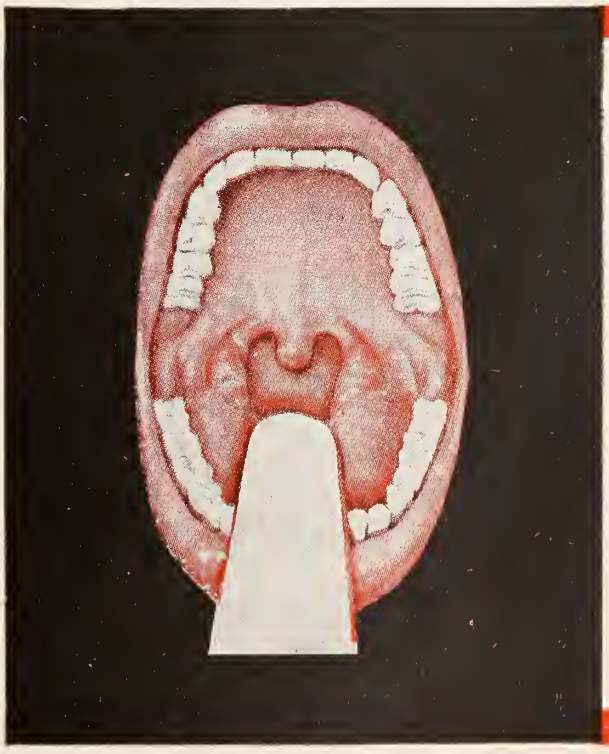

"...effective...in the treatment of a variety of infections seen regularly by the practicing clinician..." including pharyngitis, bronchitis and other respiratory infections

and "... often useful in the treatment of infections due to staphylococci resistant to one or several of the regularly used antibiotics"

"side effects . . . [are] notable by their absence"[1]

1. Carter, C. H., and Maley, M. C.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 51.

Deaths . . .

Arthur E. Stinson, M.D. who has practiced medicine in Fulton County for 54 years, died February 14 at the Lake Manitou home of a relative where he had been convalescing from an eight weeks illness. He was 78 years old.

Dr. Stinson, known to his friends as "Doctor Dick," was honored by the Indiana State Medical Association in 1954 when he was chosen "Physician of the Year" at the annual convention. He was also a member of the Fifty Year Club of the Association.

A native of Cleveland, Ohio, Dr. Stinson moved to Indiana when three years old with his parents who settled in Athens. Dr. Stinson had spent his life in that community. Following his graduation from the Central College of Physicians and Surgeons in Indianapolis in 1903, he established his office in Athens. In 1926 he moved his office to Rochester but retained his home in Athens. He had been associated with his son, Dr. Dean K. Stinson, in practice since 1929.

During his career, Dr. Stinson had been active in medical organizations and the civic and cultural affairs of his county. He had served as Fulton county coroner for 20 years and had been active as a Republican precinct committeeman. Dr. Stinson held membership in church, Masonic bodies, the Rochester Kiwanis Club, sports and social organizations.

His professional affiliations included the Fulton County Medical Society, Indiana State and American Medical Associations.

Daniel F. Paul, Jr., M.D., 35, Kentland physician, was killed February 22 when his automobile crashed into a stalled New York Central freight train one-half mile east of Morocco. The train had been halted by a broken wheel. Dr. Paul was en route from Morocco, where he had spent the evening with friends, to his home in Kentland.

A native of Illinois, Dr. Paul was a graduate of Hahnemann Medical College and Hospital of Philadelphia. He received his degree in 1949. He had practiced for a short time in Williamsport before he established his office in Kentland in 1955.

Dr. Paul was a member of the Jasper-Newton County Medical Society, the Indiana State and American Medical Associations.

Walter O. Erxleben, M.D., 48, died in his Batesville home February 22 from a heart attack suffered while seated at the breakfast table.

Dr. Erxleben had been in practice in Batesville since 1953. Previously he practiced in Chicago for 22 years, specializing in surgery. He was a 1932 graduate of the University of Michigan Medical School, Ann Arbor, and had taken postgraduate work in Europe.

Dr. Erxleben was a member of the Ripley County Medical Society, the Indiana State and American Medical Associations. He also held church, lodge and American Legion memberships.

Amos E. Ehle, M.D., a practicing physician in Wayne County for more than 50 years, died February 23 in Centerville. He was 87 years old.

Dr. Ehle, who was born in Bluffton, received his degree in medicine from the Eclectic Medical College at Cincinnati in 1896. For a short time after graduation he practiced in Oklahoma, then returned to Indiana and established his office in East Germantown in the fall of 1896. He continued to practice there until 1946. Since that time he had practiced in his Richmond home until forced into complete retirement two years ago.

Dr. Ehle was a charter member of the Fifty Year Club of the Indiana State Medical Association, having received that award in 1947. He had served several generations of families in Wayne County. Although he began his practice and be-

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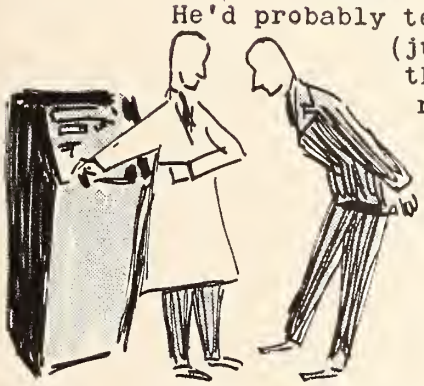

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came well known in the "horse and buggy" era, he purchased an air-cooled model automobile in 1907 to make his calls.

Dr. Ehle was a former township trustee and had been active in farm enterprises. He was a 50-year member and the oldest past master of the Cambridge City Masonic Lodge and was also a past master of the Odd Fellows Lodge at East Germantown.

Charles L. Seitz, M.D., 80, retired Evansville surgeon, died February 23 in his home near that city. He was a former vice-president of Welborn-Walker (now Welborn Baptist) Hospital and director of the Evansville Radium Institute. He was an early advocate of the use of blood transfusions and radium therapy.

A native of Evansville, he was a graduate of the University of Pennsylvania School of Medicine at Philadelphia in 1899, and served his internship at Kings County Hospital, Brooklyn. During the early 1900's he served as surgeon for two Polar expeditions. He joined the Welborn Hospital staff in 1905 and retired from that post in 1942.

Dr. Seitz was a former member of Vanderburgh County Medical Society and the Indiana State Medical Association. He received his certificate of membership in the Fifty Year Club in 1950.

Survivors include a son, Dr. Philip F. D. Seitz, formerly in private psychiatric practice in Indianapolis and now residing in Glencoe, Illinois.

Samuel J. Copeland, M.D., 79, Indianapolis nose and throat surgeon, died March 2 in his home.

Dr. Copeland was a native of Madison. He received his degree in medicine from Indiana University School of Medicine in 1909 and took postgraduate work at Tulane University and the University of Chicago.

Dr. Copeland was on the staffs of Methodist, St. Vincent's, St. Francis and General Hospitals. He was a member of the Indianapolis Medical Society, the Indiana State and American Medical Associations.

B. R. Kirklin, M.D., retired head of the department of radiology at the Mayo Clinic, Rochester, Minnesota, died March 2, in Rochester, following a heart attack.

A nationally known roentgenologist, speaker and author, Dr. Kirklin was a native of Delaware County. He received his medical degree from Indiana University School of Medicine in 1914 and practiced in Muncie for several years.

Dr. Kirklin did extensive research work in the use of x-ray, and for years had been a recognized authority on the subject. He had been a speaker on several occasions at state conventions of the Indiana State Medical Association.

Survivors include a brother, Dr. Oren L. Kirklin, Indianapolis.

Earl B. Rinker, M.D., 66, retired Indianapolis physician, died March 10 in Methodist Hospital. He had been in retirement since 1945.

Dr. Rinker was born in Kansas. He came to Indiana as a youth and was graduated from Indiana University School of Medicine in 1913. Dr. Rinker had lived in Indianapolis since that time. He did postgraduate work at Harvard Medical School.

Dr. Rinker was a member of Indianapolis Medical Society, the Indiana State and American Medical Associations.

Daniel Greenwood Tweedall, M.D., Evansville physician for 54 years, died suddenly March

12 after suffering a heart attack in his home. He was 76.

Dr. Tweedall was a native of Philadelphia. He had lived in Evansville for 64 years. After obtaining his medical degree from the University of Illinois College of Medicine at Chicago in 1903, he spent a year at Cook County Hospital, Chicago, and then entered practice in Evansville.

He instituted the first preventive medical programs against diphtheria and smallpox in the Evansville schools and for years was a leader in many civic affairs. He held staff appointments at Deaconess and St. Mary's Hospitals, was a member and former president of Vanderburgh County Medical Society, and a member of Indiana State and American Medical Associations. He was a charter member of the Indiana and American Academies of General Practice.

Avocations included farming and livestock raising. For many years Dr. Tweedall operated a farm near Evansville and spent each summer there, driving in to his office each day. He also held memberships in church, lodge and sports organizations.

Dr. Daniel C. Tweedall, Evansville, is a son.

Keith Thomas Meyer, M.D., 65, died March 13 in St. Mary's Hospital, Evansville, where he had been hospitalized for some time. He was a radiologist and had been in private practice since 1947. Prior to that time he had been head of the x-ray department of Deaconess Hospital for 18 years.

Dr. Meyer was a native of Wisconsin, was graduated from Loyola University School of Medicine, Chicago, in 1917, and later took postgraduate work at Cornell University Medical School and Harvard Medical School. He served in the Medical Corps during World War I. Dr. Meyer went to Evansville in 1924 to be associated with Welborn Baptist Hospital. He had renewed that association while in private practice.

Dr. Meyer was a member and former secretary of Vanderburgh County Medical Society, the Indiana State and American Medical Associations, the Radiological Society of North America, American College of Radiology, and many fraternal, social and patriotic organizations.

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NEWS NOTES—from State and Nation

Physicians and Lawyers to Hold Joint Meeting at Muncie

Physicians and lawyers of Delaware and Blackford Counties are to meet together at 6:00 p.m. (CDST) at the Delaware Hotel in Muncie on Tuesday, April 30. After a social hour together followed by dinner they will view the newly published motion picture film "The Medical Witness," which has been produced by the Legal Bureau of the American Medical Association as the first in a series of films on **Medicine and the Law.** Following the showing the group will discuss the film and its implications, particularly as applicable to any local problems. Such meetings as this offer an excellent opportunity for the exchange of ideas, and in some localities the outcome of such collaboration has been the development of Medico-Legal Codes which then form a useful basis for understanding and a guide for both physicians and lawyers in working out any problems in matters of medico-legal procedure.

This is the first film in a series on **Medicine and the Law** which is produced by The Wm. S. Merrell Company, pharmaceutical research laboratories, in cooperation with the American Medical Association and the American Bar Association, as a timely service to the medical and legal professions.

Following the International Congress of Otolaryngology in Washington, D.C., there will be an **International Voice Conference** in Chicago, May 20-22, 1957. Forty distinguished laryngologists, physiologists, physicists, and voice scientists from the United States, Europe and Asia will appear on the program. Participation in the conference will be by prior registration. Further information may be obtained from Dr. Hans von Leden, 30 North Michigan Avenue, Chicago 2, Illinois.

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1. Bodkin, L.G., and Ferguson, E.A., Jr.: Successful Ointment Therapy for Pruritus Ani, Am. J. Digest. Dis. 18. 59 (Feb.) 1951.
2. Fromer, J.L.: Dermatologic Concepts and Management of Pruritus Ani, Am. J. Surg. 90. 805 (Nov.) 1955.

American Goiter Association Plans New York Meeting

Members of the Indiana State Medical Association are invited to attend the annual meeting of the American Goiter Association at the Hotel Statler, New York City, on May 28, 29 and 30. The program will consist of papers and discussions dealing with the physiology and diseases of the thyroid gland.

Announcement has been made of the forthcoming meeting of the **World Congress of Gastroenterology** in the Sheraton-Park Hotel in Washington, D. C. from May 25, through May 31, 1958. The Congress is being sponsored by the International Society of Gastroenterology and the American Gastroenterological Association. Chairman for the international affair will be Dr. Harry L. Bockus.

Information regarding the program, housing and other details may be secured by writing H. M. Pollard, M.D., Secretary-General, World Congress of Gastroenterology, University Hospital, Ann Arbor, Michigan.

Dr. Wallace D. Buchanan, South Bend, has been elected a Fellow of the American College of Radiology. Dr. Buchanan is president of the St. Joseph County Medical Society, and in the private practice of radiology in South Bend.

College of Chest Physicians to Meet in New York City

The 23rd Annual Meeting of the American College of Chest Physicians will be held at the Hotel Commodore, New York City, May 29 through June 2. The scientific program will include prominent speakers on all aspects of heart and lung disease. Symposia, round table luncheon discussions, seminars and motion pictures are also scheduled.

Examinations for Fellowship in the College will be held May 30. On June 1 more than 150 physicians will receive their certificates preceding the President's banquet.

Copies of the program may be obtained from the Executive Offices, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

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Medical Assistants Select Marott Hotel for State Meeting

The Indiana State Association of Medical Assistants will meet May 25-26 in the Marble Room of the Marott Hotel, Indianapolis. All medical assistants are invited to attend.

Registration will begin at 4 p.m., Saturday with a dinner scheduled for 7 p.m. followed by a social hour. On Sunday registration will begin at 8 a.m. and the convention will open at 9, with a business meeting and election of officers followed by a luncheon. Registration fee for the event will be $2.00, the dinner will be $3.85 and the Sunday luncheon, $2.75. Further information may be obtained by contacting Miss Jeanne Woods, 5240 Clarendon Road, Indianapolis, chairman, of Miss Bertie Howe, 4509 East Washington Street, Apt. #11, Indianapolis, co-chairman.

Purposes of this organization are to unite those employed in any phase of work as a medical assistant in a doctor's office; to establish and maintain good fellowship; to inspire loyalty, integrity and efficiency; to increase the knowledge and skill of those who assist physicians, and to uphold the honor and dignity of that employment in connection with the medical service rendered mankind.

Mrs. Bettye Fisher, Evansville, was named chairman of the interim committee at the first meeting of the state group in October, 1956.

Seven medical assistants groups have been organized in Indiana, including chapters at Crawfordsville, Evansville, Fort Wayne, Indianapolis, Logansport, Richmond and Shelbyville.

Dr. Richard H. Schmidt, who has been associate radiologist at Methodist Hospital, Indianapolis for five years, has been named full time radiologist at Porter Memorial Hospital, Valparaiso. He will also have the responsibility of a newly inaugurated two-year course for x-ray technicians which the hospital board has established.

Dr. Schmidt is a native of St. Paul and received his medical degree from the University of Minnesota in 1945.

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VA Cooperating in Mass Immunization Against Polio

Veterans Administration is cooperating with the American Medical Association in a nationwide program for mass immunization of the population against polio.

Deputy Chief Medical Director Dr. R. A. Wolford of VA central office in Washington, D. C., made the announcement.

Dr. Wolford said physicians of VA hospitals and clinics will inoculate VA employes with the Salk polio vaccine on a voluntary basis when requested to cooperate by state or local medical societies.

The medical societies are spearheading the AMA—sponsored campaign to accomplish mass immunization with the Salk vaccine before summer and early fall, the seasons when a rise in the incidence of polio occurs.

Dr. Wolford said VA employes who choose to receive the Salk injection will procure the vaccine at no cost to the government. The vaccine will be administered without charge by VA physicians who volunteer for the duty at participating VA hospitals and clinics, he said.

In New York, the first area in which AMA's mass immunization campaign was put into effect, more than 800 employes of the VA hospital, clinic, and regional office in Brooklyn are being inoculated with the Salk vaccine at the hospital and clinic, Dr. Wolford said.

Special guests at the statewide **institute on intergroup relations** sponsored February 22, at Indiana University Medical Center by the Indiana State Nurses' Association were Dr. Elton R. Clarke, president of the Indiana State Medical Association, Herbert A. Schacht, president of the Indiana State Hospital Association, Miss Dora Lee Allen, South Bend, director of the National Conference of Christians and Jews, and Robert Gordon, regional director, Anti-Defamation League.

Keynote speaker for the meeting was Miss Grace E. Marr, New York, assistant executive secretary of the American Nurses Association.

The purpose of the meeting, according to Mrs. Genevieve L. Beghtel, president of the nurses association, was to explore existing opportunities for employment in the nursing profession for members of other racial groups.

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Anesthesiologists Announce State Meeting for May 7

Three out-of-state speakers have accepted invitations to participate in the annual meeting of the Indiana Society of Anesthesiologists on May 7, at the Student-Union Building, Indiana University Medical Center, Indianapolis. The meeting, for which there is no registration fee, will begin at 9 a.m.

Out-of-state speakers will be Dr. George Parker, Springfield, Ohio, Dr. Stuart Cullen, Iowa City, Iowa, and Dr. Emery A. Rovenstine, New York City.

Dr. Rovenstine will conduct a nerve block clinic Monday, May 6, at 2 p.m. at the I. U. Medical Center. All physicians are invited.

The complete program for May 7 follows:

"Induced Hypotension"—Dr. Alex Craig, New Castle

"The Clinical Use of Respirators"—Dr. Emery Hamilton, Fort Wayne

"Tranquilizers in Anesthesia"—Dr. George Parker, Springfield, Ohio

"Reflexes During Surgery and Anesthesia"—Dr. Douglas J. Giorgio, Evansville

"Hypotension, Its Diagnosis and Treatment"—Dr. Stuart Cullen, Iowa City, Iowa

"Blood Volume"—Dr. John E. Krueger, South Bend

Subject to Be Announced—Dr. Emery A. Rovenstine, New York City

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Dr. Naomi Dalton to Serve as Medical Missionary in India

Dr. Naomi Dalton, a native of Salem and graduate of Indiana University School of Medicine, left February 20, for Vellore, India, where she will serve as an instructor and anesthetist at Christian Hospital and College. Dr. Dalton was in practice in Bloomington from 1941 to 1953 when she entered the Houston VA Hospital for a special course in anesthesiology. She has since been at the Mississippi Medical College as associate director of anesthesiology. Dr. Dalton is sponsored by the Women's Society for Christian Service and the Indiana Conference of the Methodist Church. She will spend five years at the 560-bed hospital and college for 250 medical students in South India.

Dr. W. C. Robertson, Chesterton, moved March 12 to his new suite of offices in a recently completed split-level structure at 114 South 11th Street, Chesterton. His quarters include a large waiting room, two examining rooms, x-ray room, laboratory and utility rooms.

The building is constructed of concrete block and Douglas fir. Outstanding feature of construction is provision for light. Only the waiting room has conventional windows, two extremely large ones. Other rooms receive their daylight from plastic bubbles, modern skylights fashioned like gunners bubbles on aircraft.

Undergraduate scholarships worth $50,000 have been established by The Upjohn Company, Kalamazoo, Michigan, for the 1957-58 school year. Eight four-year scholarships will be given through the National Merit Scholarship Corporation, six of them to students who plan to major in pharmacy, engineering, pre-medicine, or any of the chemical or biological sciences. The other two may be in any field. Selection of recipients is handled entirely outside the Upjohn Company through tests and interviews. The National Merit Scholarship Corporation matches each donation from its endowment fund.

The first **Pan American Cancer Cytology Congress** will be held at the Eden Roc Hotel, Miami Beach, Florida from April 25 to 29. Sponsors of the Congress are The Cancer Cytology Foundation of America, Inc., Cancer Institute at Miami, Florida, Southern Society of Cancer Cytology, and the University of Miami, Florida. Invitations have been sent by the U. S. Department of State to Ministries of Health of 21 nations. All interested physicians may attend. Fee for registration is $15. President of the Congress is Dr. J. Ernest Ayre, of the Cancer Institute at Miami.

Dr. C. R. Slick, who has been in the private practice of medicine in Lynn since 1945 recently moved his home and office to Winchester to be near hospital facilities. Dr. and Mrs. Slick and their children have moved to a new home on Oak Street, Winchester, and Dr. Slick's office has also been completed. The new office building is on Elm Street in Winchester.

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Dr. Cleon A. Nafe Returns from Trip to Western Germany

Dr. Cleon A. Nafe, Indianapolis surgeon and former president of both the Indianapolis Medical Society and the Indiana State Medical Association, has returned from a several weeks tour of Western Germany. He was one of three United States physicians invited to Germany as guests of the West German government. Purpose of the trip was for the exchange of information concerning current medical practices and progress. The trio of physicians visited medical schools, hospitals, clinics and health centers and observed restoration and replacement of facilities destroyed during World War II.

Dr. Robert Bryan has returned to Kendallville to resume his medical practice after serving two years with the U. S. Army Medical Corps at Fort Detrick, Missouri, and in England. He attained the rank of major and served as battalion surgeon for an anti-aircraft artillery unit in England.

Dr. Harry C. Harvey, Fort Wayne, has been named director of the Fort Wayne Regional Blood Center effective April 1. He will supervise the collection and distribution of blood in 35 counties in northern Indiana and northwestern Ohio. Fifty-nine hospitals and 40 Red Cross chapters participate in the regional program.

Association of Pathologists to Hold Seminar at VA Hospital

The Indiana Association of Pathologists, together with the U. S. Veterans Administration Hospital, the Indiana Cancer Society and the Indiana University School of Medicine, is sponsoring its Ninth Annual Seminar on May 19 at 10 a.m. in the Veterans Administration Hospital at 1481 West 10th Street, Indianapolis. All interested members of the medical profession are invited to attend.

Subject of the seminar will be "Diseases of the Liver" and the guest speaker will be Dr. Edward A. Gall, Mary M. Emery Professor of Pathology at the University of Cincinnati College of Medicine, and director of the Department of Pathology, Cincinnati General Hospital.

A limited number of slides sets and protocols will be available for pathologists who are not members of the Indiana State Pathologists Association but who wish to attend. Orders will be filled in the sequence they are received. A $5.00 fee should be sent with application to Dr. Lester H. Hoyt, Secretary I.A.P., Methodist Hospital, Indianapolis 7, Indiana. Sets will be distributed in advance to permit time for study. All presentations at the seminar will be made by means of lantern slides.

Dr. Frank Vellios, Indiana University Medical Center, is chairman of the seminar committee.

★ *". . . best results were obtained with women 35 to 55 years of age, who complained of anxiety, insomnia, chronic fatigue and despondency."*[1]

Many physicians have reported favorable results with 'Compazine' in the mild or moderate mental and emotional conditions often associated with the menopause.

For example, in a series of 84 patients, Knoch and Kirk report outstanding results in women 35 to 55. The authors state that after 'Compazine' treatment, these women "were no longer fatigued, were sleeping well, had increased energy and showed a lively interest in their surroundings."

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1. Knoch, H.R., and Kirk, R.: Proclorperazine—A New Agent for the Treatment of Psychic Stress, in manuscript.

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

March 6, 1957

Roll call showed the following present: James W. Denny, M.D., chairman; E. H. Clauser, M.D.; Elton R. Clarke, M.D.; M. C. Topping, M.D.; Guy A. Owsley, M.D.; O. W. Sicks, M.D.

Albert Stump and Robert Hollowell, attorneys, and James A. Waggener, executive secretary.

Guests: P. T. Lamey, M.D., secretary, Miss Ruth V. Kirk, executive secretary, and Hugh W. Eikenberry, M.D., member, State Board of Medical Registration and Examination.

Membership Report:

Number of members March 5, 1957 ..... 3,616*
Number of members March 5, 1956 3,527
Gain over last year 89
Number of members December 31, 1956 4,049

* Includes 80 in military service (gratis)
100—$10 members (residents and interns)
266—senior members
54—members, dues remitted by Council
1—honorary member

Number who have paid AMA dues:
March 5, 1957 ..... 2,936**

**Includes 586 exempt members (gratis)
410 prior to 1/1/57
176 so far this year

Legislative Matters

Local

The secretary reported on the activity of the Legislative Committee, especially Dr. Wood and Dr. Wright, co-chairmen, who had met at the headquarters office with the attorney and the secretary each Wednesday noon and reviewed matters which might be of interest to the medical profession. On motion of Drs. Sicks and Clarke the secretary was instructed to express by written communication appreciation of the Association to the Legislative Committee for its important and valuable work.

National

The secretary reported on the bills before Congress which had some medical implications.

Headquarters Office

Medicare

a. The secretary reported that 331 claims had been received, 223 of which had been processed to date and approved and forwarded to Blue Shield for payments totaling $15,702.25. A detailed discussion of the operation of the plan was had, and on motion of Drs. Clauser and Sicks the secretary was instructed to employ another girl in the headquarters office.

b. The problem of filing the copies of claim blanks and a cross index was discussed and Mr. Hollowell proffered the Association a legal size filing cabinet at no cost other than transportation. The offer was accepted by consent.

Organization Matters

Letter from Dr. David F. Stone, director of the Bureau of Local Health Administration of the State Board of Health, together with an outline of a proposed survey and study in the field of tuberculosis, was presented to the Committee, as well as a letter from Dr. H. B. Pirkle, chairman of the Committee on Tuberculosis of the Indiana State Medical Association. Upon motion of Drs. Clauser and Sicks, the Executive Committee concurred with Dr. Pirkle that the USPHS tuberculosis prophylaxis trials be done in Indiana communities that have proper facilities for carrying out the tests, provided the approval of the local county medical society is obtained beforehand.

On motion of Drs. Clarke and Topping, renewal of membership in the Indiana Public Health Association was approved.

A letter from the secretary-treasurer of the Student American Medical Association, Indiana Chapter, Indiana University, was read, in which he asked the Association to underwrite his expenses in the amount of $129.20 for the purpose of attending the annual convention of the Student AMA in Philadelphia in May. The request was approved on motion of Drs. Owsley and Topping.

Requests for remission of state dues for one member from each of following county medical societies were approved: Clarke, Madison, and Knox. Request for exemption for two members of the Lake County Medical Society was also approved.

Medicare

a. Modification of the Medicare contract, known as Modification No. 6, was approved for signature by the president and secretary, on motion of Drs. Topping and Owsley.

b. Contract Modification No. 7, covering the dependents' medical care contract, was approved for signature by the president and secretary, on motion of Drs. Topping and Clauser.

c. The secretary reported on the recent meeting of the Technical Advisory Committee in Washington in which the government had agreed to attempt to have by the first of January a special claim form for use by physicians.

d. Also several policy interpretations which had been received from the government were reviewed by the committee.

Scientific program for annual convention. The secretary presented the report of the Committee on Scientific Work with its request for consideration of holding the final meeting of the House of Delegates on the afternoon of the last day rather than the morning, and upon motion of Drs. Owsley and Topping, the Scientific Work Committee was instructed to so arrange the program.

The secretary presented a letter from Blue Cross Hospital Service calling attention to the proposed increase in rates which will be effective at the next billing date, June 1, 1957.

In the absence of Dr. Harry P. Ross, chairman of the Committee on Student Loan Fund, Mr. Albert Stump reported on the Student Loan program of the Association.

The Journal

The request of the editor for an opinion regarding the carrying of an advertisement in THE JOURNAL by a Ph.D. who desires to offer his services to the profession in calibrating radio isotopes was discussed, and on motion of Drs. Topping and Clauser, carrying of the advertisement in the regular advertising section of THE JOURNAL was approved.

Statements of Receipts and Expenditures for January and February for THE JOURNAL were approved.

Medical Defense

The secretary read a letter from Mr. Don C. Hawkins, assistant secretary of the St. Paul Mercury Insurance Company, and by consent it was agreed to invite Mr. Hawkins to meet with the Executive Committee at the April meeting.

There being no further business the Committee adjourned to meet again at 6:00 p.m. on Saturday, April 27, 1957, at the Student Union Building, Indianapolis.

A modern business firm hired a psychologist as personnel manager who began by hiring a new secretary. The boss was looking on while the expert gave a psychological quiz to three feminine applicants.

"Two and two," said the psychologist.

"Four," replied the girl promptly.

To the same key words, the second girl said, "it might be 22."

The third girl answered, "It might be four and it might be 22."

After the last girl left, the expert turned to the boss. "There you have the perfect example of the efficient psychological way of hiring people. The first girl said the obvious thing. The second was suspicious. The third was cagey and wasn't going to get caught. Which do you prefer?"

The boss didn't hesitate. "I'll take the slick looking blonde with blue eyes."

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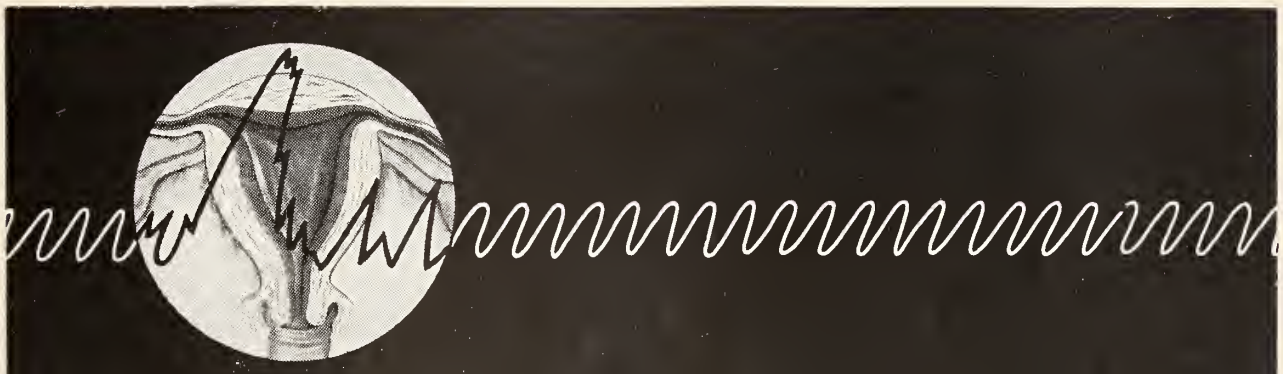

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SEARLE

News from the County Societies

Fort Wayne (Allen County) Medical Society members heard Dr. T. N. Evans, associate professor of obstetrics and gynecology at the University of Michigan Medical School, speak on "OB Emergencies" at their February 5 dinner meeting in the Chamber of Commerce.

Dr. R. W. Wilkens served as chairman and a general business meeting followed presentation of the paper.

Dr. William S. Middleton, chief medical director of Veterans Administration, was the guest speaker for the March 5 dinner meeting of the Fort Wayne society. The meeting was held in Veterans Administration Hospital. He spoke on "Aneurysms of the Aorta."

Dr. Middleton was former dean of the University of Wisconsin Medical School. He served with British and American Expeditionary Forces during World War I. During World War II he served with the U. S. Army Medical Corps and from 1942 to 1945 was the chief consultant in medicine for the European Theatre of Operations.

Co-chairmen for the program were Drs. L. A. Schneider and R. L. Hiatt. Dr. Hiatt is manager of the VA Hospital.

Dr. Leslie W. Freeman, Indianapolis, presented a paper on "Peripheral Vascular and Spinal Cord Injuries" at the March 5 meeting of **Boone County Medical Society** in the Witham Memorial Hospital, Lebanon. Nine members attended the meeting.

Carroll County Medical Society members held their February 20 meeting in the Roth Park Hotel. Special guests were wives and office personnel of the members. Thirty-eight persons attended the dinner meeting.

Dr. C. L. Wise, Camden, presented colored slides and a talk on the "Jackson Hole Country."

At the business meeting a committee composed of Drs. Max Adams, Flora, George Wagoner, Delphi, and C. L. Wise, Camden, was named to prepare information to be mailed all county residents alerting them to the need for polio immunization and explaining plans for a county-wide campaign. Questions and answers were to be prepared and placed in offices of all county physicians pertinent to the polio problem.

Forty members of the **Delaware-Blackford County Medical Society** attended the dinner meeting February 19 in the Delaware Hotel, Muncie, and heard R. S. Saylor and J. C. Herod of the Blue Shield Plan discuss the "Steel Plan" as it pertains to Muncie.

A routine business meeting was held.

Dr. Thomas B. Noble, Indianapolis, was the guest speaker at the **Fayette-Franklin County Medical Society** meeting in the Connersville Country Club on February 12. Seventeen members attended the dinner meeting and heard Dr. Noble discuss "Hospital Organization and Accreditation."

"Differential Diagnosis of Liver Disease and Functional Liver Tests" was the subject discussed by Dr. Roger P. Bissonnette, Evansville, March 13, when he spoke to the **Gibson County Medical Society.** The dinner meeting was held in the Emerson Hotel in Princeton. Thirteen members and three guests were present.

During the business meeting state legislative activities and the matter of polio shots for indigents were discussed.

Nineteen members of **Henry County Medical Society** held an evening meeting February 21 in the Henry County Hospital in New Castle.

Dr. Wendell H. Brown, Indianapolis, presented a paper on the "Management of Diabetes in Children."

Johnson County Medical Society members were guests of the Eighth Judicial Bar Association (Johnson and Brown Counties) at a reception and dinner in the Hillview Country Club, February 6. Thirty-two physicians and attorneys were present.

"The Medical Witness," a film prepared under the sponsorship of the American Bar Association and the American Medical Association, was shown. A panel discussion of doctor-lawyer relations was presented by Drs. W. L. Portteus

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and William Province, Franklin, and James Acher and Gerald Branigan, attorneys. Ivan Pogue, president of the Eighth Judicial Bar Association, presided, and Judge Robert Lybrook added his viewpoints in an open discussion which followed. Dr. R. K. Foster, chief of staff of Johnson County Memorial Hospital, also spoke for the medical profession.

The regular February 13 meeting of the Johnson County Medical Society was held in the Franklin College Student Center. Sixteen members attended the dinner and business meeting.

Square dancing followed the dinner meeting of the **Knox County Medical Society** and Auxiliary in the Vincennes Country Club on February 19. Members of the Auxiliary entertained the medical society and planned the entertainment for the 32 members and their wives who attended.

Specific policy was set regarding polio immunization by members of the **Lawrence County Medical Society** at a luncheon meeting in Dunn Memorial Hospital, Bedford, March 6. Motion was passed to make public the adopted policy of the society through the local newspaper.

Guest speaker at the luncheon was Dr. T. B. Noble, Indianapolis, who spoke on "Peritonitis" to the 23 members present.

Dr. Robert J. Rohn, Indiana University Medical Center, was the guest speaker for the meeting of the **Madison County Medical Society** at the Anderson Country Club, February 18. Dr. Rohn spoke on "Blood Dyscrasias," covering various blood diseases and their treatment.

Dr. W. D. Hart was program chairman for the meeting.

Twenty-seven members of the **Montgomery County Medical Society** held their February

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21 evening meeting in Culver Union Hospital, Crawfordsville.

The guest speaker was Dr. Hugh H. Steele, Lafayette, who discussed "Upper Gastrointestinal Bleeding."

At a business and legislative meeting of the **Indianapolis (Marion County) Medical Society** Drs. Thomas R. Sprenger and Seymour Warshaw were elected to membership and four new membership applications were received.

The regular program had been cancelled to permit discussion of legislation before the Indiana General Assembly which was of importance to the medical profession.

A memorial committee composed of Drs. Dudley A. Pfaff, chairman, K. E. Thornburg and Glenn W. Irwin, Jr., presented a tribute to Dr. Harry Baum, whose death occurred January 13.

At the March 5 meeting of the Indianapolis Medical Society, Mr. Philip Allison, Oxford University, discussed "Dysphagia." He was introduced by Dr. H. B. Shumacker, Jr., I. U. Medical Center.

Dr. James M. Leffel, president, announced that the March 19 speaker was to be Dr. John Mulholland, New York University. He also discussed recent publicity and the polio program.

Two membership applications were read and referred to the Council.

"Toxic Conditions in Pregnancy" was the topic discussed by Dr. James M. Kirtley, Crawfordsville, before the **Parke-Vermillion County Medical Society** February 20.

The dinner meeting was held in the Vermillion County Hospital, Clinton, with 10 members attending.

St. Joseph County Medical Society members held their February 12 meeting in Northern Indiana Children's Hospital, South Bend, with 95 members present.

Dr. Morris S. Friedman, South Bend, described techniques of treating calcium deposits of the shoulder tendons for the scientific program.

Dr. G. W. Larson, LaPorte, 13th District Councilor, reported on the special meeting of the Council, held in Indianapolis, to discuss the polio immunization program.

Dr. Keith E. Selby, president-elect of the St. Joseph County Medical Society, presided.

The February meeting of the **Vanderburgh County Medical Society** was combined with a "Road Show" of the Indiana Academy of General Practice. Approximately 135 physicians attended the afternoon and evening meeting in Hotel McCurdy, Evansville.

Speakers included Dr. I. J. Kwitney, Indianapolis, who spoke on "Acute Gastrointestinal Hemorrhage," and Dr. Donald F. Moore, medical director of Larue D. Carter Hospital, Indianapolis, who discussed "Modern Psychiatry: Things We Can Do; Things We Cannot Do." He presented a different discussion on the same topic at the evening meeting when Dr. Kwitney talked on "Management of Mild Cardiac Infarction."

"Liver Function Tests" were discussed by Dr. B. Jay Thompson at the March 6 meeting of the **Wabash County Medical Society.** The dinner meeting was held in the Wabash Country Club with 17 members present.

Wayne-Union County Medical Society members heard Dr. Richard L. Witt of the University of Cincinnati College of Medicine speak on "Pulmonary Physiology" at their February 12 meeting.

The dinner was held in Reid Memorial Hospital. Dr. J. R. Daggy served as program chairman.

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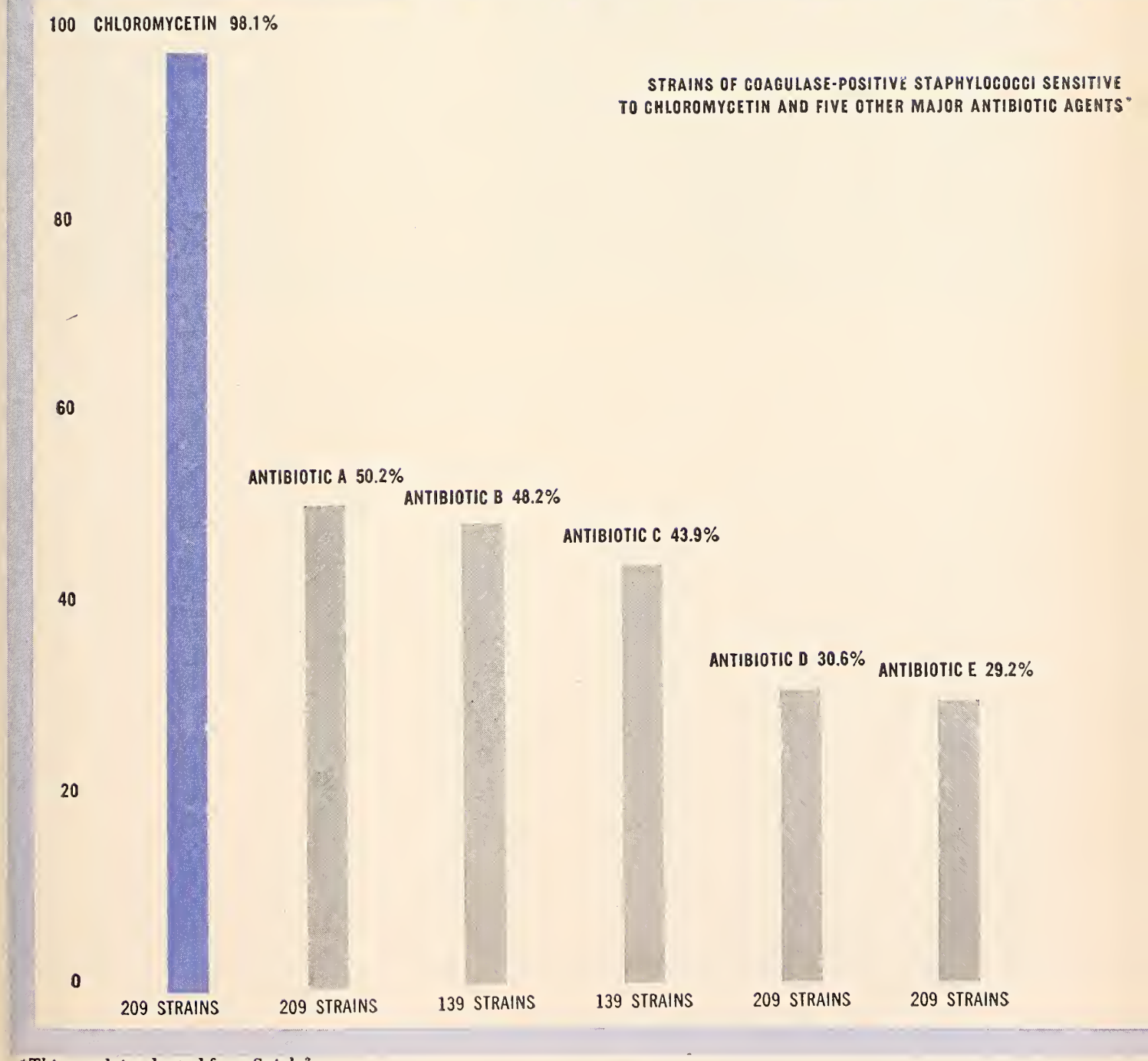

*This graph is adapted from Spink.[2]

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May 1957

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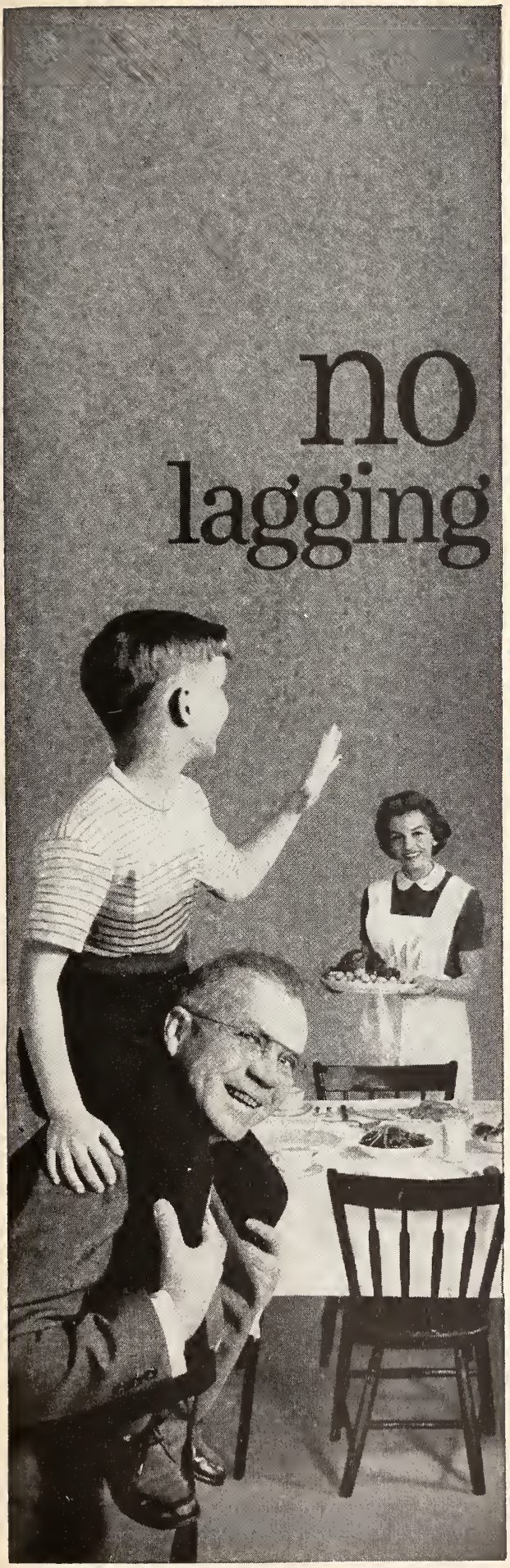
2.	Sam I. Rotman, M.D., Jasonville	J. S. Brown, M.D., Carlisle	Linton, June 6, 1957
3.	Wm. H. Robinson, M.D., Mitchell	Joseph C. Dusard, M.D., Bedford	Bedford, May 15, 1957
4.	Winship C. Callaghan, M.D., Greensburg	Robert A. Porter, Westport	Greensburg, May 8, 1957
5.	C. M. Schauwecker, M.D., Greencastle	James B. Johnson, M.D., Greencastle	Terre Haute, May 23, 1957
6.	Frank H. Green, M.D., Rushville	J. Frank Lewis, M.D., Liberty	Liberty, May 9, 1957
7.	Joseph F. Ferrara, M.D., Franklin	Arthur W. Records, M.D., Franklin	
8.	F. W. McDowell, M.D., Muncie	Clyde G. Botkin, M.D., Muncie	Muncie, June 12, 1957
9.	J. A. Van Kirk, M.D., Frankfort	Dan Tucker Miller, M.D., Fowler	Fowler, May 23, 1957
10.	E. J. DeGrazia, M.D., Valparaiso	Wm. C. Robertson, M.D., Chesterton	Gary, May 15, 1957
11.	Earl W. Bailey, M.D., Logansport	Charles L. Wise, M.D., Camden	Huntington, May 15, 1957
12.	C. Jules Heritier, M.D., Columbia City	Floyd B. Kantzer, M.D., Garrett	Pokagon State Park, May 15, 1957
13.	R. E. Nelson, M.D., South Bend	O. E. Wilson, M.D., Elkhart	South Bend, Nov. 20, 1957



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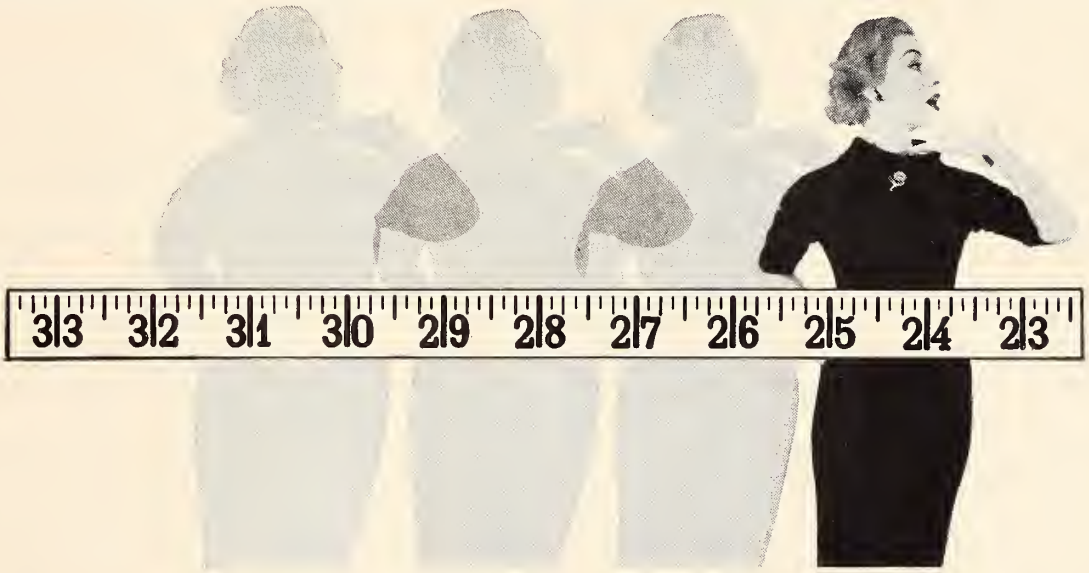

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(1) Halt, J. O. S., Jr.: Dallas Med. J. *42*:497, 1956. (2) Gelvin, E. P.; McGovock, T. H., and Kenigsberg, S.: Am. J. Digest. Dis. *1*:155, 1956. (3) Natenshon, A. L.: Am. Proct. & Digest Treat. *7*:1456, 1956.

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This summary of what is happening in Washington is prepared by A.M.A.'s capital office and airmailed to THE JOURNAL on the ninth of each month.

THE MONTH IN WASHINGTON

Washington, D. C.—By approximately the mid-term point in its first session, the 85th Congress had shown enough interest in health legislation to hold a variety of hearings, but there was no evidence that many major bills would be passed before adjournment.

Actually, it was not until three months after the session opened that the Administration sent up to Congress two bills it regards as important —one would change the doctor draft act and the other would authorize small commercial companies to pool part of their resources to stimulate expansion and experimentation in health insurance.

Even then, the Department of Health, Education, and Welfare had not released its draft of legislation for federal grants to medical, dental and osteopathic schools for construction and equipment. On this, there was some reluctance to act until Capitol Hill had decided on the administration's bill for U. S. aid to general education.

Of all these bills, indications were that progress was assured on only one, that providing some revised arrangement for the selective draft of physicians, dentists and "allied specialists." The special doctor draft act, in effect for almost seven years, is scheduled to expire on July 1. Because Defense Department insists it still needs special authority to draft physicians and other professional health personnel by professional classification, the alternative was continuation of a modified doctor draft act or changing the regular draft act.

Meanwhile, a number of other bills had been studied at hearings. They include:

Changes in medical aspect of civil aviation regulations. Witnesses are widely divided on this measure that would set up an Office of Civil Aviation Medicine within the Civil Aeronautics Administration and give the Air Surgeon General who would head the office considerably more authority than now is exercised by U. S. medical officials in this field. There was no official sponsorship of this from the federal governmental level. It was opposed by the Department of Commerce (where CAA is located) and the Civil Aeronautics Board. However, support came from the outside, including testimony from Dr. Jan Tillisch of the Mayo Clinic, Dr. William Ashe, chairman of the department of preventive medicine, Ohio State University, and Dr. Her-

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bert F. Fenwick, president of the Civil Aviation Medical Examiners. Dr. Tillisch headed an AMA *ad hoc* committee that had started a study of the problem, but he testified as an individual.

Veterans medical care. The House Veterans Affairs Committee had held extensive hearings on a bill to further restrict admission of nonservice connected cases to Veterans Administration hospitals, but there were no developments beyond that to encourage sponsors of this legislation.

Civil defense reorganization. Here again a wide split developed at the hearings on just how to reorganize the federal government's participation in civil defense. The Administration wanted to strengthen the U. S. civil defense arm (the Federal Civil Defense Administration), but without going to the extent of making a cabinet-rank Department of Civil Defense, which is the goal of Chairman Chet Holifield (D., Calif.) of the subcommittee that had studied civil defense for more than a year.

Control of barbiturate and amphetamine drugs. The objective of bills before the House Interstate health subcommittee is to extend federal control to take in the manufacture, compounding, processing, distribution and possession of habit-forming barbiturates and amphetamines. This would be achieved by demonstrating that intrastate control of the drugs is essential to achieve interstate control, a philosophy advanced for years by some federal officials.

While manufacturers, compounders, processors and handlers would have to list their names and places of business with HEW and to maintain complete records, physicians would not have to comply with these regulations.

ECONOMY ADVOCATES LOSING

Pressures for economy that had been evident early in the session seemed to lose their effectiveness when Congress really set to work on the budget for the Department of Health, Education, and Welfare. Whereas in first (nonrecord) votes the House cut scores of items, it simply reversed itself when roll-call votes were demanded in the final go-around.

As an example, no reductions at all were made in funds for the research institutes, $50 million was restored for grants to help build water pollution treatment plans, $1.3 million was restored to the Food and Drug Administration. A $5 million cut in money for general public health grants to states was sustained by the House—but this money will have to be provided later if the House estimate of the extent of the obligation proves too low.

Economy advocates tried without success in the House to cut $21 million off money for the Hill-Burton hospital construction program.

While in theory the Senate is privileged to make its own cuts in a money bill coming to it from the House, in practice the Senators generally restore much of the money cut by the House and occasionally (as last year) vote large boosts over House figures. So the possibility now is for even higher health and medical budgets before the appropriations bills finally are enacted.

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Recent Observations

On Self-Regulated Schedules For Infants

Genetically acquired behavioral predispositions enable the normal baby to regulate its feeding intake and periodic hunger sensations, its feeding habits. These physiological regulatory forces may be satisfied by adapting the formula content and feeding period to the individual needs of the infant. It involves a sensible compromise between too rigid a schedule, geared to the clock and too lax a schedule, based on self-demand feedings. Such is the current objective: for either extreme can lead to infant feeding difficulties.

The newborn may become a feeding problem if the prescribed formula is excessive or the feeding schedule rigid. Every time he is awakened abruptly from satisfying slumber to be fed forcefully, the baby gradually loses his enthusiasm for the food and begins to resist the feeding. The young infant may balk at the crude introduction of a new food or feeding procedure without the proper prelude of gradual adaptation of taste, color, consistency and quantity.

The older infant weaned from bottle to cup may reject milk or go on a hunger strike. Devoted to his bottle he resents its sudden deprivation. It takes a certain readiness for weaning to make that change agreeable. Later the infant becomes somewhat independent of his mother and arbitrary with his food. What he enjoyed yesterday, he rejects today. If he distorts the diet for a day and his mother resorts to force, a feeding problem is in the making. Sensible decorum will solve these little difficulties before they become big behavior disturbances in childhood.

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Letters to the Editor:

February 28, 1957

To the Editor:

The truth of the conclusions of medical science rests upon the solidity of the assumptions leading to the conclusions. It comes as a shock, therefore, to receive in the mail today an informational booklet for physicians which flagrantly violates editorial standards by deleting from a purportedly and otherwise completely reproduced article a short paragraph which discusses the assumptions that are introduced by the authors to guard against the unwary acceptance of the conclusions. The reader is not informed of the deletion.

The booklet is the latest publication of the National Foundation for Infantile Paralysis. It is Number 4 of a series entitled, Information for Physicians on the Salk Poliomyelitis Vaccine (February 1957). The editor is Dr. Thomas M. Rivers, Medical Director of NFIP. The article is "A Preliminary Report on Surveillance of Poliomyelitis in the United States in 1956" prepared by members of the Poliomyelitis Surveillance Unit of the United States Public Health Service. This report originally appeared in mimeographed form for release on January 26, 1957, and was distributed by PSU to public health officials and others. The section that Dr. Rivers takes it upon himself to delete is as follows:

> "Assumptions underlying these analyses introduce several sources of potential bias. Case reports were received through morbidity reporting systems of widely varying accuracy. Overall population figures and vaccine usage figures (particularly for commercial supplies of vaccine) were necessarily estimates. Variations in geographic and age-specific vaccination and attack rates could not be completely accounted for. Risk of exposure was assumed to be equal in the two populations and constant throughout the study period. Although attempts have been made to minimize the effect of these sources of errors, interpretations of the results must necessarily be guarded." Two additional sentences following this paragraph are also deleted but are not pertinent to the discussion.

The reader can decide for himself whether this deletion is or is not intended to deceive the physician. The fact remains that NFIP has seen fit to decide what physicians of this country shall or shall not read about the Salk Vaccine. Its principle seems to be that *its* ends justify any means. The means reflects the principle that American physicians are not capable of being trusted with the full story. As a result, public money which the Foundation holds in trust is expended in a campaign of systematically misleading physicians who have the real responsibility for the public's health.

It is ironic that the regimentation of physicians' minds, the medical profession's greatest fear, comes, in this instance, not from government officials whom we can at least vote for or against every four years and whose budget we can watch over, but from a so-called voluntary

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In order to satisfy these extremely high nutritional requirements, "protective" foods supplying liberal amounts of protein, vitamins, and minerals should predominate in adolescent diets.[3] Such foods include meat, poultry, fish, milk, eggs, vegetables and fruits, and whole-grain or enriched cereals and enriched bread. Accessory foods commonly eaten by adolescents to satisfy emotional needs may provide energy, but are commonly responsible for obesity and should not take the place of the "protective" foods.

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1. Toverud, K. U.; Stearns, G., and Macy, I. G.: Maternal Nutrition and Child Health. An Interpretative Review, Washington, D.C., National Research Council, National Academy of Sciences, Bull. No. 123, 1950, p. 115.
2. Proudfit, F. T., and Robinson, C. H.: Nutrition and Diet Therapy, ed. 11, New York, The Macmillan Company, 1955, p. 271.
3. Martin, E. A.: Roberts' Nutrition Work with Children, Chicago, The University of Chicago Press, 1954, pp. 231-236.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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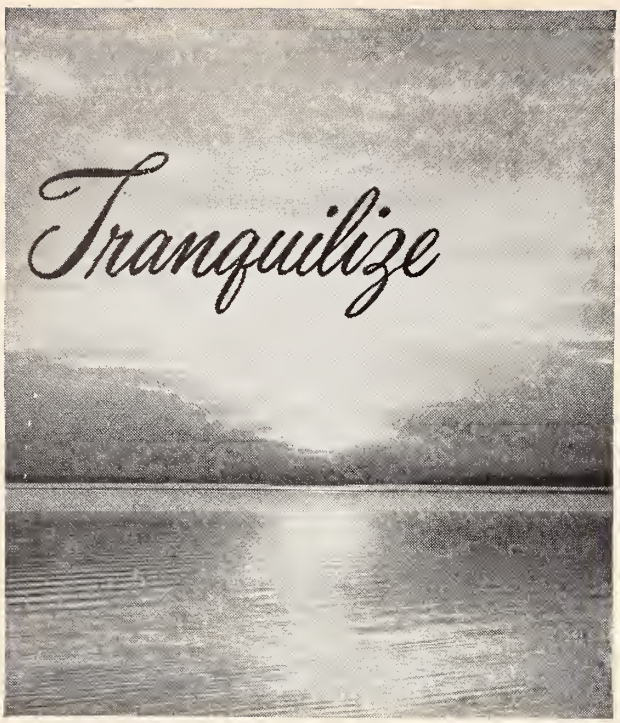

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Letters to the Editor (continued)

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Herbert Ratner, M.D.
Public Health Director
Oak Park, Illinois

DELAWARE-BLACKFORD COUNTY MEDICAL SOCIETY
Muncie, Indiana

March 14, 1957

Frank B. Ramsey, M.D., Editor
The Journal
201 Hume Mansur Building
Indianapolis 4, Indiana

Dear Dr. Ramsey:

The enclosed editorial appeared in the Muncie Star, March 7, 1957. Several doctors in our county feel it is a very fitting tribute to a wonderful doctor and hope that you will publish this in the State JOURNAL in the near future.

Sincerely,
I. S. Hostetter, M.D., Secretary
Delaware-Blackford County Medical Society

The following is reprinted from the Muncie Star:

"HER DOCTOR OF YEAR"
Shirley Barnet

Today I had an occasion to take my father to see Dr. Clay Ball, and this was our first time in many months to talk to this wonderful man.

He showed us his 50-year pin for his years of medical practice in our community, and I could not help but marvel at this doctor who was still going about his duties most efficiently though he is nearing his eightieth birthday.

The pride in his pin was well founded, and yet I couldn't help but feel what a small memento it was, considering the many fine things he had done throughout these many years.

On the way home from his office my father told me some of the meritorious deeds our doctor had done. A few of these happened before he brought me into the world, such as the time when he was the jail physician. Night after night he was awakened from a well earned sleep to administer to an inmate who had taken one too many and was threatening not only his own health, but his cell mates.

My father went on to speak of the many times he walked from the old Star office building, the location

Continued

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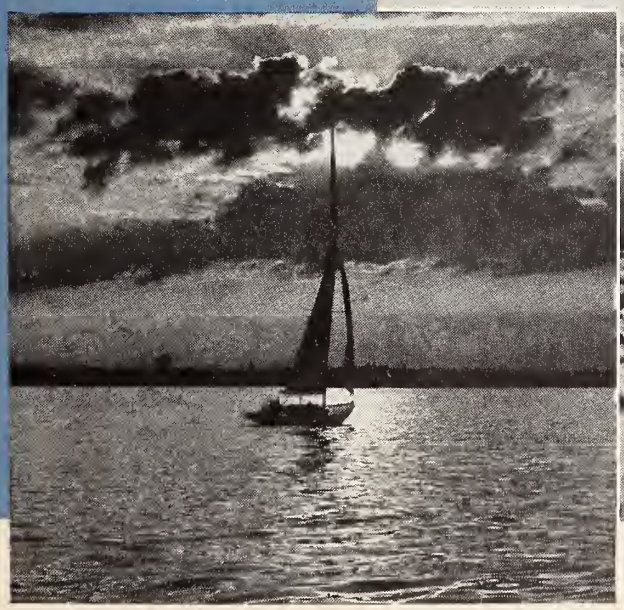

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of his office at the time, to the outskirts of town to bring relief to someone desperately ill, or to help bring another little Hoosier into the world.

He walked these miles time and time again, through ice, sleet, snow and rain, and complained not at all if the folks he helped were temporarily out of funds and just couldn't see their way clear to pay for his services.

Dr. Ball couldn't afford to hire one of those horse-drawn cabs in those days, and I imagine many automobiles were in evidence on Walnut Street long before he had the necessary capital with which to purchase one.

In fact there were a lot of things he couldn't afford, for he was then, and now, a man who believed that his job was to do good and that material compensation could come as it would.

Yes, that little pin denoting 50 years' service can well be worn proudly, but a lengthy book could be written about this gentleman, doctor, and friend who is beloved by so many.

I don't know how one goes about nominating "The Doctor of the Year," but we as a family would most certainly cast our vote in his direction.

May God bless him and keep him healthy and strong, for hundreds of us in this community are just that way because of him.

ROCKY MOUNTAIN CANCER CONFERENCE
Denver, July 10, 11, 1957
835 Republic Bldg. Denver 2, Colorado

March 18, 1957

Frank B. Ramsey, M.D.
201 Hume Mansur Building
Indianapolis, Indiana

Dear Dr. Ramsey:

Each year for the past 10 years we have held a regional Cancer Conference in Denver which has been well received by the medical profession. Registrations have included doctors from almost every state in the Union.

This year's program will be one of the best ever held and I thought that you could help us develop interest among your fellow practitioners.

The guest speakers who have accepted invitations to speak at this meeting are: Drs. Richard H. Overholt, Boston, Surgeon; L. Henry Garland, San Francisco, Radiologist; Seymour M. Farber, San Francisco, Internist; Joseph Bank, Phoenix, Gastro-Enterologist; Alton Ochsner, New Orleans, Surgeon; Joseph A. Cunningham, Birmingham, Pathologist; and Arthur T. Hertig, Boston, OB-GYN Pathologist. The two symposia will be based upon Cancer of the Lung and Cancer of the Stomach.

In addition to the excellent postgraduate education there will be a banquet with the theme of the evening being fun and relaxation.

Keep in mind the vacation wonders of Colorful Colorado and plan to spend some additional time seeing our State.

As the program develops we will send you additional information and if you need a Colorado hotel and motel guide we will be happy to send one upon your request.

I hope your plans for July will include our Rocky Mountain Cancer Conference.

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Books: Reviewed

ANESTHESIA FOR OBSTETRICS. By Robert A. Hingson, Professor of Anesthesia, Western Reserve University, Director of Anesthesia, University Hospitals of Cleveland and Louis M. Hellman, Professor of Obstetrics and Gynecology, State University of New York, College of Medicine at New York; Director of Obstetrics and Gynecology, Kings County Hospital. Cloth Bound $12.50. Pp. 344. J. B. Lippincott Company, Philadelphia.

In this text book the authors discuss anesthesia from a broad outlook. Any factor which may influence the conduct and outcome of labor and delivery receives consideration. They present the technique which seems preferable at the time of writing, but point out that their conclusions are subject to review and change, and that the method presented may not be suitable in all circumstances and situations.

The reader senses the spirit of cooperation which is essential between anesthesiologist and obstetrician for optimum results. In certain areas individual responsibility is necessary. Those of us who have heard Dr. Hingson know his bubbling enthusiasm and feel it in this book. Dr. Hellman must have this same zeal, for this atmosphere is present throughout the text.

Safety for mother and baby is a prime consideration. For better understanding of the problems involved presently and in the future the opening chapters cover pain relief in broad perspective and the history of obstetrical anesthesia with statistics to emphasize points.

The chapter on agents and methods of pain relief including psychological lobotomy follows an outline giving the indications, contraindications, advantages, disadvantages, precautions, pitfalls and complications. Directions are concise and complete. The discussion of the psychological aspects of pain control covers such topics as decor, lighting, music, noise, and an evaluation of drugs, techniques, and doctors by the parturient. Maternal and fetal complications give rise to problems not found in normal circumstances. The approach to these is refreshing. The authors give cogent reasons for their choice of pain relief. Easily understood and interesting graphs present the statistics. Suggestions which will reduce morbidity and mortality appear frequently.

The chapter on maternal and infant safeguards gives the treatment of emergencies. The authors strongly urge the establishment of a newborn recovery room in all institutions having over 2,000 deliveries per year. For maximum use and efficiency of this safeguard one should classify infants as to physiologic state and order more thorough care for the infant in distress.

There is a discussion of equipment, records, and the organization of a 24 hour anesthesia service.

The style is pleasing and direct; the format is excellent, the illustrations well done and the subject thoroughly covered. Anyone interested in this field from either point of view should study this superb book.

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Abstracts:

THE ADRENAL CORTEX IN RELATION TO RETINAL AND RENAL VASCULAR LESIONS IN DIABETES

Gibbs, Gordon E., and Henn, Mary J.: Nebraska State Medical Journal 41:427-429, November 1956.

The relationship of adrenocortical function to diabetes is well summarized in this short article. It is known that there is some alteration in adrenal cortical function in poorly controlled diabetics—this has been in the direction of adrenal hyperfunction. It is, however, not known if a similar relationship exists in well controlled diabetics. Those diabetics who die of glomerulosclerosis have shown histiological changes suggestive of a physiological increase in production. This has been interpreted as due to the chronic stress of diabetes. Additional arguments to promote this thesis are:

1. Kimmelstiel-Wilson renal lesions have been reported in non-diabetics on prolonged corticotropin therapy.
2. Transient retinopathy has been observed during intravenous corticotropin therapy in non-diabetics. These eye findings have also been known to appear or progress during pregnancy and to subside thereafter—probably correlated with increased adrenocortical function which takes place during pregnancy.
3. Disappearance of retinopathy in young diabetics following the development of pituitary insufficiency.
4. The reversal of vascular lesions following adrenalectomy or hypophysectomy.

The University of Nebraska studies suggest from their data that the urinary excretion of hydoxycorticoids is higher in uncontrolled than in controlled diabetics and further that this excretion level is even greater in those diabetics with retinitis. While other studies are not in complete agreement with these findings the study is of interest and the known facts are well outlined.

HERBERT FRANK, M.D., South Bend.

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Discontinue Shipment of Medical Books to Korea

The American-Korean Foundation and the United States Army Medical Service have announced the discontinuation of their joint project of shipping medical books contributed by individual physicians, medical schools, hospitals and state and local medical societies to Korea.

Books should not be sent to the Sharpe General Depot in California as in the past, for facilities no longer exist for packing and transshipping to Korea.

In making the announcement, Howard A. Rusk, M.D., President, American-Korean Foundation said, "the response of physicians and medical groups throughout the country for our appeal for books for Korean medical schools has been so generous that further contributions are not needed." As a result of this program, Dr. Rusk stated, over 77 tons, valued at $76,000, of medical texts, references and periodicals have been shipped to Korea for distribution to Korean medical schools.

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Dr. Cleon A. Nafe to Address Medical Assistants' Meeting

At the first full-scale state meeting of the Indiana State Association of Medical Assistants, Dr. Cleon A. Nafe, Indianapolis, will be the principal speaker. The meeting will be held in the Marott Hotel's Marble Room on Saturday evening, May 25.

Remarks will also be made by Dr. Elton R. Clarke, Kokomo, president of the Indiana State Medical Association; Dr. James M. Leffel, Indianapolis, president of the Indianapolis Medical Society; Mr. James A. Waggener, ISMA executive secretary; Mr. Joseph E. Palmer, Indianapolis Medical Society executive secretary; and Albert Stump, legal advisor.

Registration will begin at 4 p.m., May 25 and sessions will conclude on May 26 at 3 p.m. following installation of new officers. Medical assistants wishing information should contact Miss Jeanne Woods, 5240 Clarendon Road, Indianapolis, Indiana.

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Breast & Thyroid Surgery, One Week, June 17
Gallbladder Surgery, Three Days, June 24
Surgery of Hernia, Three Days, June 27
Fractures & Traumatic Surgery, Two Weeks, June 17

GYNECOLOGY—
Office & Operative Gynecology, Two Weeks, June 17
Vaginal Approach to Pelvic Surgery, One Week, June 10

MEDICINE—
Electrocardiography & Heart Disease, Two-Week Basic Course, July 8
Hematology, One Week, June 17

RADIOLOGY—
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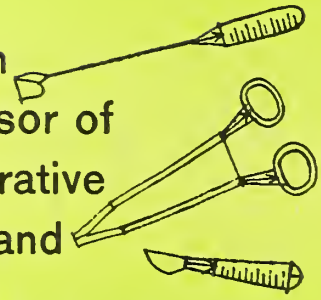

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Air Force to Activate Indiana Reserve Medical Training Center

The Continental Air Command, United States Air Force, has announced the activation of 10 Air Force Reserve medical training centers, one of which will be located at Indianapolis. The local unit will be the 625th USAF Hospital. The training centers will be manned by Regular Air Force personnel and will train Air Reservists on a not-on-active-duty basis, with 48 training periods and 15-day active duty tours each year. Special short school training tours will also be authorized. The training program will include refresher continuation and qualification training for prior service officers and airmen, as well as technical training introduction for non-prior service airmen.

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The Fourth Estate Looks at Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

HONEST YOUTH

Delphi Journal: A Delphi youth received an unusual compliment this week. After being injured in an automobile accident, he was taken to a doctor in a town near the place where the accident occurred in the Francesville-Medaryville area. When he returned the next day to pay for the medical services, the doctor commented that this was the first time in 17 years of practice that any of many strangers who had received first aid after accidents and promised to come back to pay, ever actually did so. Delphi should be proud that it was a Delphi youth who broke that record.

(Quoted in the Indianapolis Star)

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 50 — May 1957 — Number 5

Low Back and Sciatic Pain

F. KEITH BRADFORD, M.D.

Houston, Texas

WHEN PATIENTS PRESENT THEMselves with the complaint of low back pain, with or without sciatic pain, it is necessary to make every effort to reach an accurate diagnosis. Although there are many entities which can cause these symptoms, the commonest cause is some mechanical disturbance in the lower spinal joints. The posterior articulations undoubtedly play a part in many low back syndromes, but it appears likely that the lower lumbar intervertebral discs are more usually involved. The mechanical origin of the symptoms is often suspected by the patient and can usually be established by appropriate questioning.

It must be emphasized at the start that the annulus fibrosus is the capsule of the joint between the vertebral bodies. Intervertebral disc disturbances should only be termed "ruptured intervertebral disc" when nerve compression has resulted from posterolateral extrusion of nucleus pulposus through a defective annulus fibrosis. This restriction of the term "ruptured disc" is important, even though degenerated or injured intervertebral discs may have technically "ruptured" in some other direction. We can properly think of the "ruptured disc" with its accompanying sciatic pain as being one serious and characteristic phase of intervertebral disc injury in general.

Emphasis first on the "mechanical" group of cases with back and sciatic pain or with back pain alone is important because the mechanical characteristics of the pain serve largely to differentiate these patients from all others. When ruptured disc has occurred, there are usually marked variations in intensity of the sciatic pain in different postures, although this variability may become inconspicuous late in the course of some cases.

Anomalies are exceedingly common in the lumbosacral area. They have received attention in the past at great variance with their true importance. It can be stated, however, that the presence of four or six true lumbar vertebræ confuses the neurological picture in that involve-

Presented at annual convention of the Indiana State Medical Association, October 1956, in Indianapolis, Indiana.

ment of the "sixth lumbar nerve" may produce the clinical findings of either fifth lumbar or first sacral nerve involvement, or something in between. It can generally be said that a lumbar vertebra, well assimilated into the sacrum and in line with the sacral vertebræ, acts as a sacral vertebra, and that rupture of the intervertebral disc separating it from the sacrum rarely occurs. Spondylolisthesis can be placed among anomalous conditions, although its exact origin is obscure. Separation of a vertebra at the pars interarticularis permits the body of the vertebra to slip forward without carrying its neural arch with it. The annulus fibrosis of the intervertebral disc (and its reinforcing ligaments) alone holds the vertebral body from slipping forward unimpeded. It can be seen, then, that the intervertebral disc becomes quite abnormal with advancing degrees of spondylolisthesis. Characteristic ruptured disc can occur in spondylolisthesis, but other mechanisms of nerve compression are also possible.

In separating the "mechanical" cases from the others, it helps a great deal to know the sites of pain referral. At times, pain develops in areas quite remote from the area primarily affected by the pathological process *without involvement of a nerve root or trunk.* Although mechanisms of such referred pain are obscure, certain patterns are fairly well understood. With painful disturbances of the lower two intervertebral discs, pain is likely to be most intense across the middle of the back near the affected level. It is often more pronounced on one side than the other, and often traverses the area over the sacroiliac joint. This fact misled many earlier observers to postulate a pathological process in the sacroiliac joint when none was present. Pain may be referred about the iliac crest or over the sacrum. In a minority of patients, pain is referred into the buttocks and posterior thighs, rarely below the knees. If such pain is always milder than the back pain and never present independently, it is rarely a result of nerve root compression. Many patients with involvement of one of the lower two intervertebral discs experience severe groin, lower abdominal or testicular pain. The testicle may be tender to touch, and tenderness often extends along the spermatic cord. After a variable period, pain referred to the groin, lower abdomen or testis usually improves, even though the back pain is unabated. Occasionally, such referred pain persists severely. Groin pain which, in my opinion, resulted from intervertebral disc injury has more than once prompted repair of an incomplete indirect inguinal hernia. Referred pain of these types can accompany the nerve root pain of ruptured disc, but often the phase of back and referred pain is past when root pain becomes the prominent symptom. Nevertheless, on two occasions in my experience, marked testicular pain accompanying typical sciatic root pain has been relieved by surgical removal of herniated nucleus pulposus. It was thought that distention of the tear in the annulus fibrosus produced the testicular pain, not the involvement of the nerve root.

Another not uncommon complication observed in patients with back and sciatic complaints is the occurrence of a feeling of numbness or pain in the area of the lateral thigh supplied by the lateral femoral cutaneous nerve. This complication is usually seen later in the course of low back sprain. At times, it can be attributed to surgical garments or braces which press on the lateral femoral cutaneous nerve, but often it must result from postural changes secondary to the primary disorder. Usually, diminished sensation and a feeling more of numbness than pain are complained of. Painful paresthesias do occur as described in "meralgia paresthetica." In fact, this must be considered a variant of that condition. When reassurance is given the patient that a sensory nerve is merely being compressed as it emerges through a narrow opening in the membrane about the muscle, he usually tolerates the annoyance of the symptoms quite well.

RUPTURED INTERVERTEBRAL DISC

The symptoms and signs of ruptured intervertebral disc are usually characteristic, and are comparable in their specificity to the symptoms and signs of intermittent claudication or peptic ulcer. As is necessarily true of so common a disease entity, however, the aggregate number of atypical cases is considerable.

The history of injury is usually obtained, although there is often a long interval between injury and early back disability and the subsequent development of sciatic pain. Lifting, with some feature of awkwardness or uncertainty of footing, is the commonest type of injury producing ruptured disc. Trivial occurrences may precipitate

the more severe symptoms, but are probably not etiologic. Typically, sciatic pain extends from hip to ankle, although pain may predominate in relatively narrow zones. Aggravation of sciatic pain by coughing, straining or sneezing is highly indicative of an intraspinal lesion as its cause. Relief by lying down is often experienced early in the course. Back pain generally recedes to secondary importance when compared to the sciatic pain. The course is variable, depending upon activity and other less predictable factors.

The objective findings can be divided into general signs and specific root signs. Reduced lumbosacral lordosis and sciatic scoliosis are extremely important when present, but do occur in back conditions without nerve root involvement. Limitation of flexion and extension of the lower spine is common. The jugular compression test is often positive in those patients with accentuation of pain by coughing or sneezing, rarely in others. Suggestible patients say "yes" to anything. It is therefore desirable to "control" the test by performing some additional maneuver which should not accentuate pain. The sciatic nerve stretching test is almost uniformly positive on the side of sciatic pain, a sign of little specificity. It is of considerable importance, however, if stretching on the non-painful side aggravates pain on the painful side, often termed a "crossed Lasègue sign." Paravertebral tenderness at the level of involvement is often present, but the reproduction of remote root pain by firm paravertebral pressure is a more useful diagnostic finding. In fourth lumbar herniations, weakness of the dorsiflexor muscles of the toes is often marked, and sensory changes may be demonstrable in the fifth lumbar dermatome. Similarly, herniation at the lumbosacral disc compresses the first sacral root, with resulting diminished or absent ankle jerk, hypesthesia of the lateral foot and posterolateral calf and, occasionally, weakness in rising to the toes. Root findings, clearly demonstrable (but often undemonstrated), will often "cinch" the diagnosis when other symptoms and signs are of doubtful significance.

The "disc syndrome" varies considerably, but the "text-book picture" predominates. A positive clinical diagnosis can often be made with several signs lacking. It is important that the presence of atypical features discounts the diagnosis of ruptured disc as much as does the absence of characteristic signs.

ROENTGENOLOGICAL EXAMINATION

Every patient with serious back or sciatic disability must have an adequate x-ray examination. Although intervertebral disc narrowing, especially narrowing of the fourth lumbar disc, may corroborate the diagnosis of ruptured disc, the chief purpose of the x-ray examination is to exclude (or diagnose) demonstrable lesions of the spine, such as spondylolisthesis, or primary or secondary bone tumors, osteoporosis, pathological or other fractures, etc.

The significance of osteoarthritic changes in the lumbosacral spine is far from easy to evaluate. Pathological changes in the lower lumbar intervertebral discs are increasingly common after the second decade. These changes may be reflected by roentgenological changes. However, in some instances, symptoms are much more prominent before than after these roentgenological changes have occurred. Many paradoxical situations exist. Advanced lumbosacral osteoarthritis is often demonstrated in patients from whom no history of back symptoms is obtainable. These changes are often demonstrated immediately following an injury, actual or alleged, which is too recent to have contributed to the changes. Intervertebral disc narrowing is exceedingly common after operations for ruptured disc, even when narrowing has not been present before. The change or absence of change in intervertebral disc stature, however, is no index to the clinical course of the patient. Nevertheless, absorption of cortex of intervertebral surfaces, often termed "osteitis," appears in patients having severe, persistent "spasms" of back pain after intervertebral disc surgery.

It has been surprising that osteoarthritic changes have often remained stationary over periods of many years, as demonstrated by repeated x-ray examinations. This suggests that some provocative factor, probably injury, initiates the process, which continues over some concrete period of time, perhaps 6 to 24 months. It appears likely that a history of prior disability is often suppressed or minimized for litigation or insurance reasons. Nevertheless, one cannot doubt every negative history with positive x-ray changes. Certainly, trauma is a frequent factor in the production of osteoarthritis of the lumbosacral spine, although other causative factors doubtless contribute.

Myelography, utilizing Pantopaque (ethyl

iodophenylundecylate), has become a fairly standardized procedure, but must not be performed indiscriminately. All too frequently, defects due to inconsequential anatomic variations or alterations are made the basis of a diagnosis of ruptured intervertebral disc. Discography may prove to have a limited usefulness, but too often it shows only that intervertebral discs are degenerated without giving positive evidence of posterolateral rupture.

Special procedures, then, useful as they may be, serve only in a very limited capacity to establish the diagnosis and determine the proper therapy in cases of low back and sciatic pain.

DIFFERENTIAL DIAGNOSIS

The most common errors in diagnosis are those within the mechanical back pain (joint disturbance) division. The insistence that a patient with "only" a back problem has a ruptured disc is probably the commonest error, especially if some irregularity in the myelographic films is misinterpreted as indicating a ruptured disc. On the other hand, inadequate examination or superimposed functional factors will often result in a missed diagnosis of ruptured disc in the back sprain group. There is, of course, no justification for the often encountered contention that patients with severe symptoms must have ruptured disc and that patients with mild symptoms have "simple" back sprain. The converse is often true, and the prolonged disabling nature of certain severe back sprains must be recognized.

Malignancy, either by direct extension or by metastatic growth, may produce neurological symptoms and signs resembling those of ruptured disc. Usually, there are atypical features which are recognized by those familiar with the ruptured disc syndrome. The neurological involvement is often too extensive or at a non-characteristic level. Back symptoms may be totally absent. It is important to be ever aware of this tragic cause of sciatic pain and to remember that bone involvement is apparent by x-ray examination only when quite advanced. Back pain alone, of course, can also be of malignant origin. It is likely to have less variability and fewer "mechanical" features than the pain of back sprain.

Cauda equina tumor can, at times, produce a clinical picture indistinguishable from that of ruptured disc. However, again, each symptom or sign which is definitely at variance with the *more constant syndrome of ruptured disc* should arouse suspicion. Spinal fluid protein is likely to be higher (above 100 mgms. per cent), and the myelographic appearance is often different.

The presence of a tumor or suppurative process along the course of the sciatic nerve must be held in mind as a cause of sciatic pain. Any lump, swelling or tender area of which the patient complains must be carefully palpated.

In rare instances, intermittent claudication results in gluteal or thigh pain rather than in the more characteristic calf pain. The production of pain only by exercise and the absence of arterial pulsation over the femoral and other arteries establish the diagnosis.

Compression of the fifth lumbar nerve in its intervertebral foramen probably cannot be differentiated from ruptured disc. However, it appears likely that the root findings are more outstanding when compression is by a ruptured disc. Also, accentuation of pain by coughing, sneezing, or by jugular compression speaks for a diagnosis of ruptured disc. If intervertebral motion is stopped by the same process which narrows the intervertebral foramen, pain is less likely to result. Actually, a nerve can continue to function even through considerably compressed, if no motion is possible at the site of compression.

TREATMENT

Less radical conservative treatment methods utilizing boards beneath the mattress, graduated activity and an adequate back support appear to be as successful as traction methods. I have no objection to procaine injection of tender points, but feel that little is proved in this manner as far as etiology of pain is concerned. I object strongly to injection of stronger solutions. The selection of patients for intervertebral disc surgery is made on a basis of severe, persistent disability. The accuracy of the diagnosis of ruptured disc is of great importance because the results in negative explorations are mediocre. There is no justification for spinal fusion being performed simply because a ruptured disc is being operated upon. However, the combined procedure is properly elected in certain patients with specific back symptomatology, especially if their occupations are heavy manual labor. It is probably more difficult to evaluate the necessity for surgical intervention in workmen's compensation

cases, but if the diagnosis is accurate and the standard of surgery high in these cases, results will not be far behind those in non-compensation cases. Back symptoms and, more rarely, root symptoms may be severe during the postoperative period in patients who will ultimately obtain good results. Sympathetic understanding and adequate symptomatic treatment are essential in postoperative management. If a postoperative disability rating must be given before operation is performed, it should be higher than the anticipated degree of disability.

SUMMARY

The altered intervertebral disc may produce two main types of disability. First, there is the symptom-complex of the intervertebral disc's failure as a joint. Second, there may be added to this symptom-complex the additional symptoms and signs of nerve compression by displaced portions of the intervertebral disc. The appraisal of back and sciatic disabilities is primarily a clinical one. This clinical appraisal may be aided by x-ray and myelographic studies, but cannot be replaced by them.

NEW X-RAY DIAGNOSTIC DEVELOPMENTS POINT TO GREAT MEDICAL ADVANCES, PREDICTS NOTED PHILADELPHIA RADIOLOGIST

Some radiological examinations have reached a state where soon it will be possible to routinely study many more human organs as they actually are functioning, and conclusions can be drawn about the presence of disease before any structural changes are even suspected.

That is the prediction of an outstanding Philadelphia radiologist, Dr. W. Edward Chamberlain, in a recent issue (December, 1956) of *The American Journal of Roentgenology, Radium Therapy and Nuclear Medicine.* Title of Dr. Chamberlain's article was "Benefits to Mankind Through Integration of Physiology and Radiology."

Some of his conclusions:

With the help of new electronic devices, x-ray motion pictures have become an important tool for the physiologist. Short bursts of film may be made at sequence rates of 30, 60, 100 or even 200 frames per second, then projected at 12 to 24 frames per second for "slow motion" analysis.

Once a strip of x-ray motion picture film has been exposed and processed, it is available for prolonged and repeated study without further exposure to the patient.

The practicing physician will certainly be able to make earlier diagnosis with the help of such examinations, for it is well known that disturbances of function often precede disturbances of morphology.

"As the integration of physiology and radiology continues, we may be sure that the cost of equipment for cineroentgenography, whatever it may be, will not stand in the way," Dr. Chamberlain concluded.

Intrathoracic Mixed Neuroblastoma and Ganglioneuroma in Childhood

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Muncie

NEUROBLASTOMAS are one of the commonest malignant neoplasms to be encountered in infancy and childhood. The majority of these tumors occur in the first few years of life. Although neuroblastomas are found most frequently in the abdomen, they also may arise within the thorax along the sympathetic chain. Only 5 per cent of the neuroblastomas studied by Gross were found in the thorax. Marchand[4] in 1891 first recognized that those tumors resembled developing sympathetic ganglia.

It is of interest that some of these tumors have been shown microscopically to contain transition stages between the malignant neuroblastoma and the benign ganglioneuroma. Indeed, in some cases, clinical transformation from a malignant neuroblastoma to a benign ganglioneuroma has been observed with survival of the patient even in the presence of distant metastases and a seemingly hopeless prognosis. The first such survival was recorded in 1927 by Cushing and Wolbach[1]. In this case, the neuroblastoma was biopsied and was regarded as non-resectable. Surprisingly, the child survived and 10 years later the remainder of the tumor was removed. At this time, it was found that the tumor had become entirely transformed into a benign ganglioneuroma. The potential capacity of these tumors to undergo maturation into a more benign type of neoplasm is of considerable importance in evaluating their prognosis and in outlining their therapeutic management.

Gross[2] has suggested that as much of the neuroblastoma should be removed as is possible and that radiation therapy should be employed following operation. In the study carried out by Koop and his associates[3], it was reported that removal of all or a major portion of the tumor, even in the presence of metastases, seemed to carry a better survival rate than was found when biopsy alone was performed on an "inoperable" tumor. They questioned the value of radiation therapy.

The age of the patient at the time of the appearance of the tumor is also of considerable prognostic significance. Gross found a survival rate of 45 per cent in children under two years of age and of only 11 per cent in children over two years.

Relatively few mixed neuroblastomas and ganglioneuromas of the thorax have been reported. Only 3 of the cases described by Gross were of this type. Two of the cases of Koop and his associates were classified as malignant ganglioneuroma. No cases of intrathoracic neuroblastoma differentiating into ganglioneuroma could be found in the files of the Indiana University Medical Center.

Due to the infrequent occurrence of this type of neoplasm within the thorax, it has seemed desirable to report a case in which a large tumor composed of both neuroblastoma and ganglioneuroma filled approximately one half of the right hemithorax in a 5 year old girl.

* From the Surgical Service, Ball Memorial Hospital, Muncie, Indiana and the Department of Surgery, Indiana University School of Medicine. Aided in part by a grant from the James Whitcomb Riley Memorial Association.

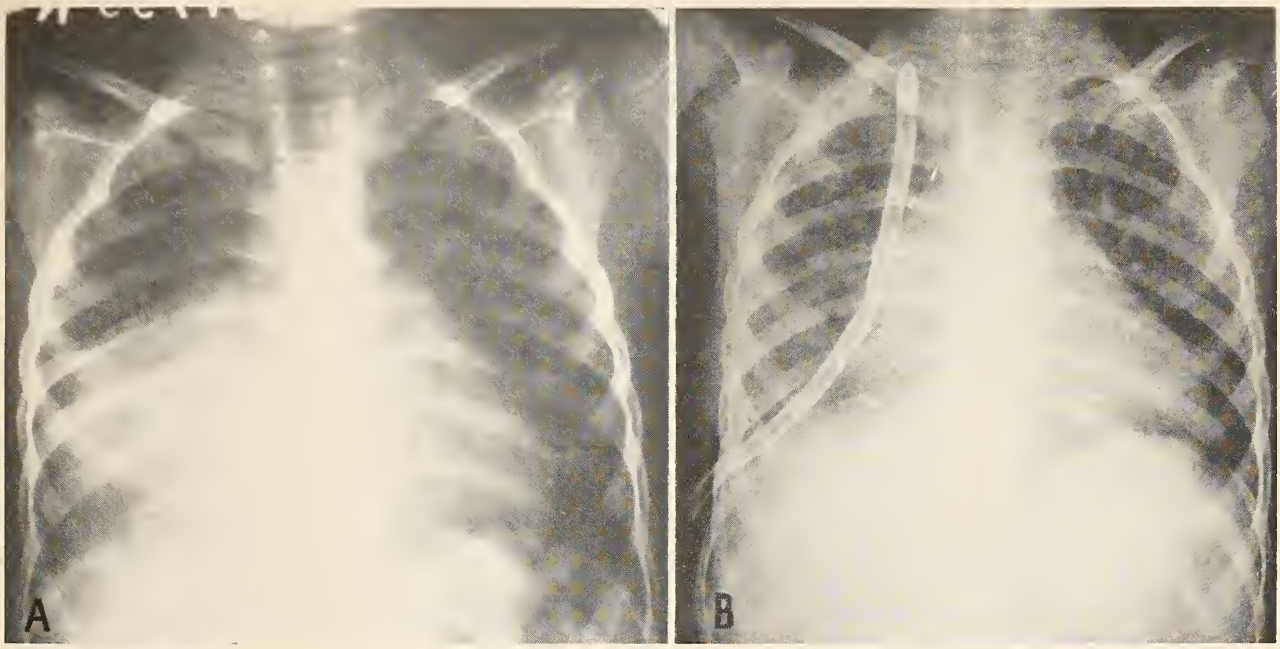

Figure 1. Roentgenograms taken before and after removal of the large intrathoracic neuroblastoma-ganglioneuroma. The film in (A) is an overexposed one which shows the limits of the tumor mass and areas of calcification within the mass. In (B), silver clips are shown demonstrating the margins of the residual tumor in the intercostal spaces which could not be removed grossly.

CASE REPORT

The patient, a five-year-old white girl, was admitted to the Ball Memorial Hospital on January 24, 1956 because of irritability, weakness, anorexia, lethargy and pain in her back and neck. These symptoms were first noted approximately six months prior to admission. A progressive increase in weakness was observed in the two weeks prior to admission, and she was thought by her mother to be febrile on several occasions.

On physical examination, she was found to be poorly nourished, pale and irritable. She was rather sullen in her reactions. Her temperature was 99.2 degrees Fahrenheit. Her neck resisted flexion and she complained of pain when flexion was attempted. The lymph nodes were not enlarged. There was dullness to percussion over the posterior inferior portion of the right hemithorax. Breath sounds and fremitus were also decreased over this area. Palpation of the right lower thorax and lower thoracic spine was painful. All other physical findings were essentially within normal limits.

A lumbar puncture was performed on the day of admission. The cerebrospinal fluid pressure was found to be increased to 220 millimeters of water. The protein, sugar, and cell determinations were all within normal limits. Roentgenograms of the chest showed a large mass which occupied virtually all of the inferior half of the right hemithorax. Over-exposed films revealed presence of calcifications of various sizes scattered throughout the mass (Fig. 1). No abnormal findings were encountered on bronchoscopy. Tuberculin and histoplasmin skin tests were negative. No growth was obtained on repeated blood culture. Gastric washings were negative for acid-fast bacilli. Nose and throat cultures were within normal limits. The patient remained quite irritable and anorexic. She continued to have a fever which ranged from 99 to 101 degrees Fahrenheit. She experienced pain in her back which caused her to cry out on motion. Her moderate nuchal rigidity continued. Penicillin and streptomycin were given for two weeks without improvement. She began to complain of pain in her lower extremities and gradually became unable to walk because of the pain and unsteadiness.

On February 2, a right thoractomy was performed through the fifth intercostal space. A large firm mass was found to fill the inferior half of the right hemithorax. It was fixed to the posterolateral chest wall and adjacent vertebrae. It arose a few centimeters above the diaphragm. A portion of the mass extended into fourth, fifth, and sixth intercostal spaces. This portion of the tumor was biopsied and was identified as neuro-

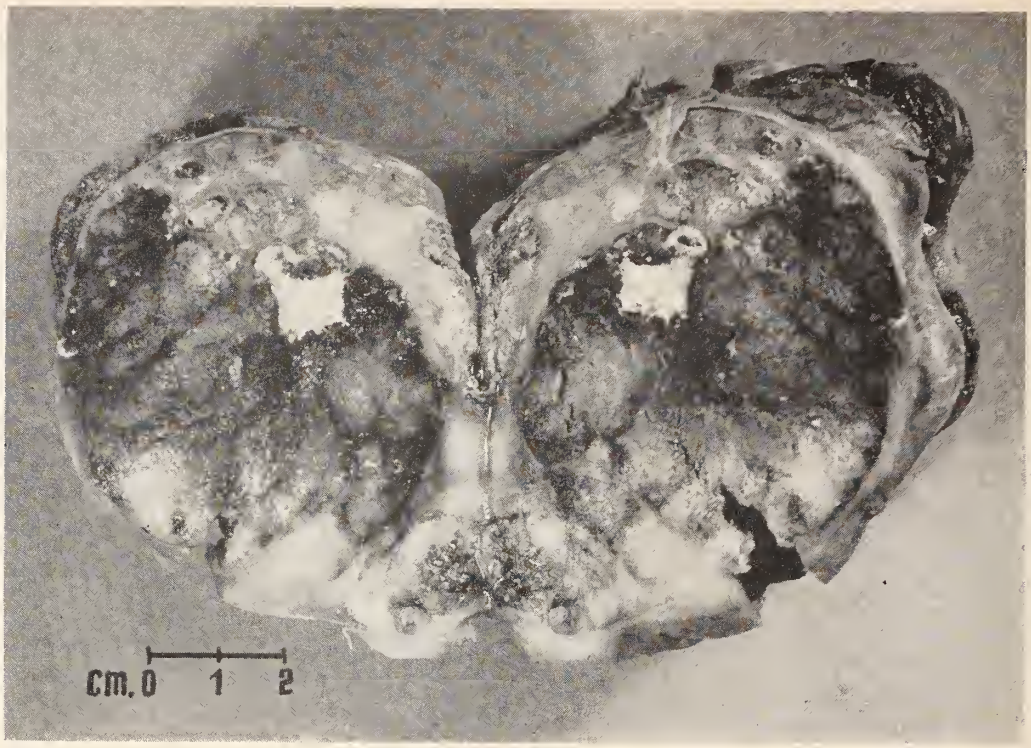

Figure 2. Photograph of one section of the surgical specimen showing the more solid cortex and the softer central portions as they appeared grossly.

blastoma on frozen section. The pleura over the mass was then incised and the bulk of the tumor, approximately 95 per cent, was removed. No attempt was made to remove that portion of the tumor which had invaded the several intercostal spaces. The margins of that portion of the neoplasm which was left behind were outlined with silver clips. It was hoped that this might assist in the postoperative administration of roentgen therapy. The chest wall was closed in layers and a catheter which was left in place during the closure was aspirated and withdrawn. She tolerated the procedure well and was returned to the ward in good condition.

Grossly, the tumor consisted of a firm, bosselated cortex of a well differentiated "benign" ganglioneuroma and a softer central mass of neuroblastoma. The demarcation between the two tumors was readily visible on gross examination (Fig. 2) and was quite distinct microscopically (Fig. 3). The central portion was fairly homogeneous. It consisted of a rather uniform hypermitotic cell with occasional rosette formations. The outer portion consisted of well differentiated ganglioneuroma with frequent scatterings of ganglion cells.

The postoperative course was uneventful. The patient recovered well from the effects of the operation. On February 6, 1956 she was started on roentgen therapy. This was carried out six days a week for three weeks. The radiation therapy to the chest was given through posterior and lateral portals providing a total of 2880 r depth dose. The patient was discharged from the hospital on February 28. One week after the completion of X-ray therapy, X-ray evidence of bony metastasis to the skull and long bones was found. Multiple soft tissue metastases appeared and progressed. Her condition deteriorated rapidly and she expired on June 10. Permission for autopsy was not obtained.

DISCUSSION

Although it was not possible to remove all of the malignant tumor in this case, it was hoped that the resection of approximately 95 per cent of the tumor mass followed by radiation therapy would give this child a chance for survival. The result was disappointing. It should be noted that the majority of neuroblastomas, especially in this age group, tend to follow a rather rapidly fatal course and that those patients who die usually do so within a relatively short period after diagnosis.

Complete removal of the tumor was clearly impossible because of the extensive intercostal extension. It was suspected that the neurogenic difficulties experienced by this patient had resulted from intradural invasion of the tumor. The occurrence of a soft, highly malignant central

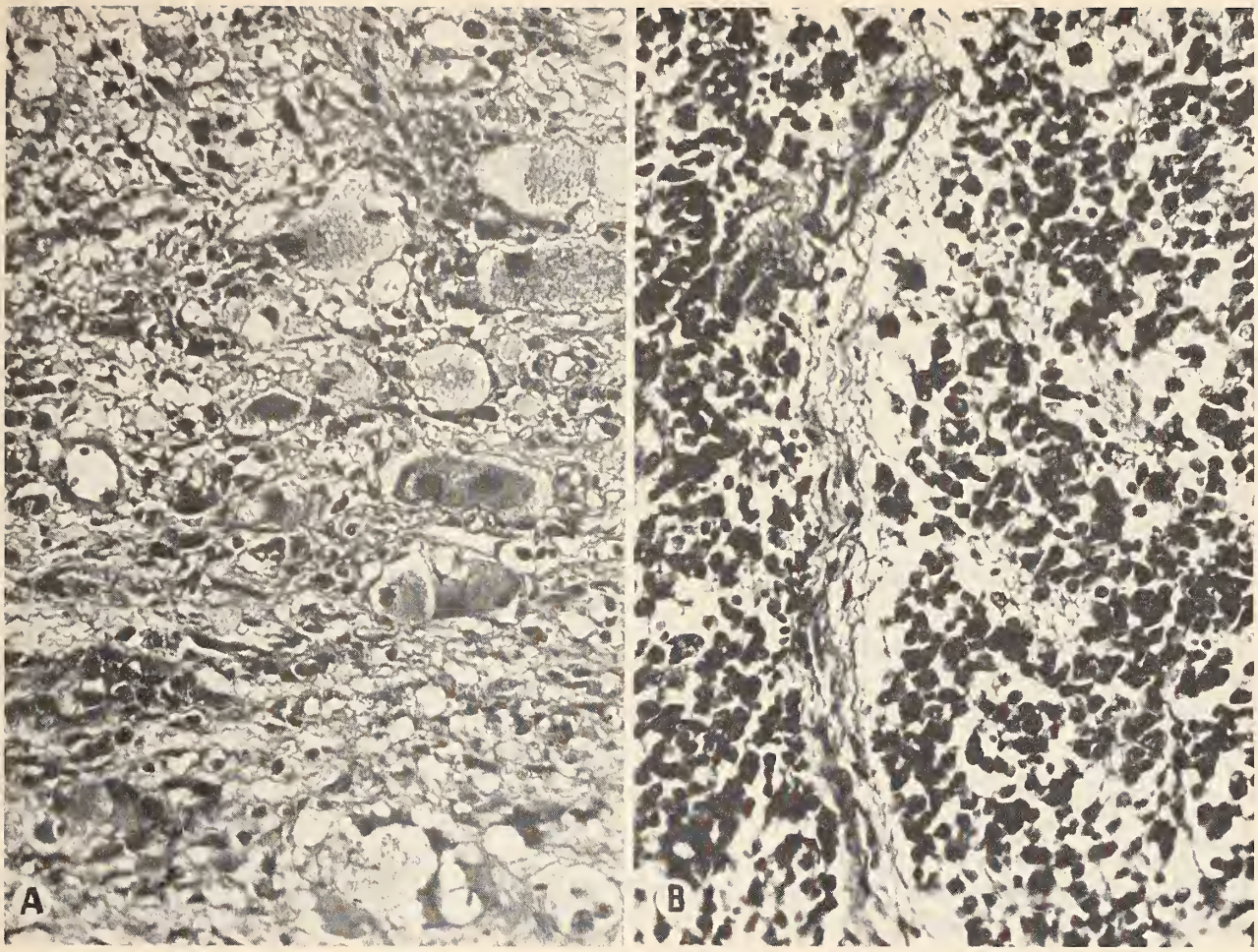

Figure 3. Photomicrographs taken through an area of ganglioneuroma (A) and through an area of neuroblastoma (B).

mass of malignant neuroblastoma surrounded by a more firm cortex of benign ganglioneuroma was also of interest.

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Abdominal Pregnancy: A Case Presentation and Discussion

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Gary

TRUE ABDOMINAL PREGNANCY of primary type is indeed rare. Only 25 cases have been reported to date.[1] However, many cases of secondary abdominal pregnancy occur. These may be due to tubal abortion, rupture of the uterus, or mechanism in which a fertilized ovum or partially developed fœtus is extruded into the abdomen. It is estimated that there is one abdominal pregnancy in each 2,207 deliveries.[2] The case described here occurred in Gary, Indiana, from May to November of 1955.

THEORY

Many theories have been proposed to explain the development of abdominal pregnancy. Some workers have proven to their satisfaction that the spermatazoa can go transperitoneal and fertilize an egg. Bourgeois and Shapiro have proved by serial sections of a double uterus that a sperm can go transperitoneal and produce a pregnancy in a uterine cavity that has no connection with the cervix or a tubal opening.[3] Probably the majority of abdominal pregnancies result from faulty migration of the fertilized ovum due to some pathology in the uterine adnexæ.

Twin abdominal pregnancy and abdominal pregnancy with an intrauterine pregnancy can also occur. In 1954, two Russian writers reported an extrauterine pregnancy with delivery of twins via the intrauterine route.[4] This condition has also been reported more than once in the same person.[5] There are published articles on this subject in nearly all languages; hence we know it is not uncommon.

Diagnosis and management of abdominal pregnancy are frequently difficult. A discussion of these follows the case presentation.

CASE HISTORY

The patient was a colored female, age 33, admitted to the hospital May 19, 1955 with complaints of vomiting, pain in the lower half of the abdomen most severe on the right side, abdominal distention, frequency of urination, and a temperature of 99.8. The admitting diagnosis was appendicitis. She had been seen in the office a few times in May complaining of abdominal distress. She had had her last menstrual period in March. Pelvic examination in the office showed no uterine enlargement or abnormality. Physical examination revealed she had lost considerable weight, had a marked distention of the abdomen, and had a possible enlarged uterus at this time.

History revealed her to be a Para V, Gravida VI. Her oldest child was 19 and the youngest 2 years old. She had had two miscarriages, the last of which was in February, 1954, at two months' gestation. She had had no serious illnesses. Her last pregnancy was terminated by medical induction of labor because of a toxemia of pregnancy at 8 months. Laboratory work showed (1) severe anemia with R.B.C. of 2,000,000; (2) the urine was loaded with pus. A diagnosis of pyelitis of pregnancy was made. She was given two pints of whole blood, but after this her count was still only 2,200,000, Hgb. 74%. She was given two more pints of blood, and her count went to 4,000,000 red cells and Hgb. 76%. She was treated with penicillin and improved enough to be released May 24.

The patient was not seen again until July 9, at which time she was admitted again to the hospital with the following complaints: (1) severe pain in the lower abdomen, (2) severe pain in the upper right side of the abdomen, made

worse by breathing, (3) marked abdominal distention again, with vomiting and frequency of urination. Her red count was 2,600,000, with Hgb. 54%. She had no shoulder pain. Physical examination revealed the uterus was enlarged to the size of a four month pregnancy. She ran a very stormy course for the next several days. She was treated with Wangensteen suction, fluids, penicillin, achromycin, and two pints more of whole blood. Her main complaints were abdominal pain of a very severe type, distention, constipation, and anemia of an unexplainable type. A tentative diagnosis was made: pyelitis, possible gallbladder disease, pneumonia with pleurisy, or a combination of these. Her temperature ranged from normal to 102 degrees. On July 16, she had some icteric tinge to the sclera. By this time she was clinically improved, the distention of the abdomen was reduced, and she was able to eat some soft foods. X-rays of the abdomen, a flat plate, showed no sign of any bowel obstruction.

We were getting rather desperate at this time about making a correct definite diagnosis. With the jaundice and the subsequent transfusions, we now had to check the possibility of a hepatitis. On July 19, more laboratory tests and X-rays were ordered. A flat plate of the abdomen showed fœtal parts of about five months' gestation. Laboratory work showed the urine loaded with pus; uterine culture produced no growth; sickle cell tests were negative; and the Coombs test was negative. A cephalin flocculation test was negative. The serology, CO_2 combining power, blood chlorides, nonprotein nitrogen, and blood urea nitrogen were all within normal limits. The van den Bergh test showed a delayed reaction. Bilirubin was 7 mg. per cent on July 21, and a week later it was 6 mg. per cent. An A-Z test made on July 20 was negative. The R.B.C. on July 20 was 4,000,000. The patient felt well at times and was able to eat, but at other times complained bitterly about abdominal pain and about movements of the baby, which caused severe pain about the umbilicus and the gallbladder area. An X-ray of the abdomen showed a fœtus of five months' gestation, and the radiologist thought it was an intrauterine pregnancy. X-rays of the colon showed a dilatation of the entire colon with upward displacement of the transverse segment.

From the latter part of July until the first week of October, the patient was in the hospital. All this time her complaints were about the painful movements of the foetus and a marked anorexia. She lost 15 pounds, dropping from 112 to 97. She was given liver extract, vitamins, proteins, and some demerol as needed for pain. She was improved enough by October 15 to be released. Her diagnosis was hepatitis. The pregnancy was allowed to progress and no termination of it was agreed upon.

The patient was not seen again until October 27, at which time she came to the hospital because she thought she was in labor. After a few hours she said her pain was gone and she was dismissed the next day. It was obvious by now that she was in the last trimester of pregnancy. She was not seen any more until November 6, when she came back to the hospital with the same pain, only more severe. She stated the movements of the baby were very distinct and very close to the outside of her abdomen. After a careful examination we decided we were dealing with an abdominal pregnancy. X-ray revealed a fœtus in a transverse position and high in the abdomen, not in the pelvis. The cervix was very edematous and greatly enlarged. There was a mass in the pelvis thought to be a fibroid of the uterus or the corpus of the uterus.

Now we were sure of the diagnosis. We decided to wait a few weeks, or perhaps days, depending on the patient's condition, and try to get a viable baby. As the patient's condition began to deteriorate by November 6, we took her to surgery for a laparotomy, the diagnosis being abdominal pregnancy. At time of surgery we found the baby lying outside the uterus, the feet on the right side under the rib margin, and the crown on the left side. There was no amniotic sac as such, just fibrinous remnants attached to the jejunum and the transverse colon. The placenta was attached to the parietal peritoneum near the bladder and to the remnants of the right ovary and broad ligament. The baby appeared grossly to be normal. The placenta was inadvertently ruptured in the operative process, so we removed it. Removal caused a severe blood loss but was accomplished easily since the attachments to the right ovary and broad ligament gave us a rather small area to suture for control of blood loss. The ovary and round ligament on the right side were never found; no doubt they were absorbed by the placental attachments. The patient was given 3 pints of blood during her surgery. The uterus was enlarged to the size of a four

months' pregnancy. No other abnormal condition was found in the pelvis, and the patient left surgery in good condition.

The baby weighed 3 pounds and 4 ounces. It had no gross defects, but it lived only 12 hours. The autopsy showed prematurity and this was all. The mother made an uneventful recovery and left the hospital on the tenth postoperative day, happy at last to be rid of the severe pain that had plagued her so long.

DIAGNOSIS OF ABDOMINAL PREGNANCY

This case demonstrates a diagnostic problem and shows how long a patient with a complicated pregnancy can go without a definite explanation for her difficulties. Several internists and gynecologists saw her at various times during her hospital stay, but all agreed to treat her symptomatically and conservatively. Definite diagnosis of abdominal pregnancy in the last trimester is usually easy. The patient herself many times will make the diagnosis. She will say the baby is too close to the surface or that things just feel "different this time." Many times she will say that a hand or foot is too close, and she can feel it easily. Such statements are very important, especially from a multipara.

These are some of the more important points in making a diagnosis of abdominal pregnancy: (1) persistent abdominal pain, (2) displacement of the cervix, (3) high transverse lie or any high position of the fœtus, (4) signs of fœtal death, such as missed abortion or missed labor, (5) identity of any extrauterine mass, (6) pitocin test of Corwin and McCord[5], and (7) X-ray findings, i.e., foetal parts and their position. Many times all signs fail, and we may be in doubt after much deliberation. The difficulty is illustrated by the findings at Grady Memorial Hospital, Atlanta, Georgia, where, in a group of 28 cases treated, 12 cases were diagnosed on the first visit, and 16 cases were diagnosed before surgery.[6]

Once a diagnosis is made, laparotomy is the treatment of choice in 90 percent of the 502 cases reviewed. This decision holds regardless of the stage of gestation. In the same group of cases, 80 percent chose to leave the placenta in place in the abdomen or pelvis. Twenty percent chose to remove the placenta. The mortality figure for these cases was 2%. When the placenta was left in, death was due to pulmonary embolism, infection, and a visceral fistula, in the order stated.[7]

Only one fourth of all extra uterine pregnancies diagnosed after five months will result in viable babies.[8] About one third of these babies will have major or minor defects incompatible with life. Approximately one third of all babies delivered as abdominal pregnancies will live eight days or more.

SUMMARY

1. True primary abdominal pregnancy is rare, but secondary abdominal pregnancy is not.
2. In making this diagnosis, perhaps the most important aids are a knowledge of the condition itself and the high position of the foetus.
3. When the diagnosis is made, most writers agree on surgery at once.
4. Most writers agree to leave the placenta undisturbed.

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Clinico-Pathological Conference: Annual I. U. Postgraduate Symposium on Malignancy

*Case II: An 11 year old boy with increased intracranial pressure**

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ORVILLE T. BAILEY, M.D.

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SUCCESSFUL SURGERY for the treatment of intracranial neoplasms can only be undertaken after much time and effort has been spent in determining that a lesion is present, and its exact location. Intracranial neoplasms produce subtle changes in their victims, and the greatest clinical acumen is required to detect them early enough to be helpful. Skill in the use of the neurological history and examination is being acquired by an increasing number of physicians. Special ophthalmological, otolaryngological, radiological, radioisotope, and electroencephalographic technics are being developed and improved to make the early detection and exact localization of brain tumors safer and more certain. In spite of these technical advances each patient with a brain tumor must rely upon his family doctor to suspect its presence and start him on the road to diagnosis and treatment before he is disabled.

This illustrative case was presented on March 28, 1956 at Indiana University Medical Center as part of a symposium, designed to bring together current information on the diagnosis and treatment of intracranial neoplasms.

Participants:

Harry M. Zimmerman, M.D.—Chief Laboratory Division, Montefiore Hospital, New York, N. Y.

Joe B. Penneybacker, M.D., F.R.C.S.—Director Neurological Surgery, Radcliffe Infirmary, Oxford, England.

Paul C. Bucy, M.D.—Chief of Division of Neurological Surgery, Chicago Wesley Memorial Hospital, Chicago, Illinois.

Douglas Buchanan, M.B., Ch.B.—Professor of Neurology and Pediatrics, University of Chicago.

Harold O. Peterson, M.D.—Clinical Professor Radiology, University of Minnesota.

Reginald Bickford, M.B., Ch.B.—Consultant and Head of Laboratory of Electroencephalography and Neurophysiologist, Mayo Clinic, Rochester, Minnesota.

William T. Peyton, M.D.—Professor of Surgery and Director of Neursosurgery, University of Minnesota, Minneapolis, Minnesota.

Percival Bailey, M.D.—Distinguished Professor, Neurology and Neurosurgery, University of Illinois.

John A. Campbell, M.D.—Professor and Chief of Radiology, Indiana University.

Edward B. Smith, M.D.—Professor of Pathology, Indiana University (presiding).

Orville T. Bailey, M.D.—Professor of Neuropathology, Indiana University.

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* Presented March 27, 1956 during the Ninth Annual Symposium on Malignancy sponsored by the Indiana Division of the American Cancer Society at Indiana University Medical Center, Indianapolis.

This is the second and last case reported by the authors. The first case appeared in the April 1957 issue.

Robert F. Heimburger, M.D.—Associate Professor of Surgery and Chief of Neurological Surgery, Indiana University.

Philip White, M.D.—Assistant Professor of Neurology, Indiana University.

Harry Boyd, M.D.—Chief Resident in Neurological Surgery, Indiana University.

Robert Campbell, M.D.—First Assistant Resident in Neurological Surgery, Indiana University.

Dr. Robert Campbell: The patient was referred to the James Whitcomb Riley Hospital by Dr. Victor Varner of Evansville, Indiana, and admitted for the first time on June 25, 1943, at the age of 3 and 6/12 years. Thirteen days before, his parents noticed a "lump" in his upper chest. X-rays of the area were interpreted to show a sarcoma of the middle third of the right clavicle. A biopsy of the mass was taken, and because the microscopic diagnosis was in some doubt, the child was referred to the Riley Hospital. Since birth, the child was known to have a nodular, hairy, pigmented area of skin over the right face, neck and shoulder. Examination confirmed the presence of a mass in the middle third of the right clavicle. On July 19, 1943 the medial two-thirds of the right clavicle was resected. The mass was thought to be malignant at the time of surgery, even though it was fairly well demarcated; there was no abnormality of the regional lymph nodes. After some discussion regarding the miscroscopic diagnosis, the patient was discharged from the hospital on August 1, 1943.

Dr. Peterson: In the X-ray at the time of first admission, the end of the clavicle has a peculiar appearance which does not suggest a primary tumor (Figure 1). The bone is thinned out, and the cortical markings are lost all the way around. More lateral in the clavicle, there is a cup on the under surface of the clavicle. In the chest film there is a large solid mass which obscures the lung. With the arms in a similar position, the right clavicle runs uphill, and the left proceeds in its normal direction as though the mass were largely below the right clavicle and pushing it up. This suggests a lesion that arose outside the clavicle and then invaded it. There are other parts in the history which would suggest that these lesions are neurofibromata.

Dr. Smith: The pathologic specimen was approximately four cms. in diameter. A represent-

Figure 1. X-ray of clavicle, showing displacement and a mass in the middle third.

ative section of it shows merely regenerating bone with nothing of a neoplastic nature.

Dr. Robert Campbell: Following the resection of the medial two-thirds of the patient's right clavicle, he was followed in the Orthopedic Out-Patient Clinic for two years, and was readmitted to the Riley Hospital August 23, 1945, because of a noticeable droop of his right shoulder. During this admission a bone graft taken from the left tibia was placed between the remaining distal end of the right clavicle and the manubrium. This graft healed well. The boy was followed for two more years in the orthopedic clinic, during which he grew and developed normally.

He was not seen again until January 9, 1951 when he was admitted to the Neurological Surgery Section because of headaches. The headaches started 1½ years before this admission and became more severe in the few weeks before admission. The parents also reported a progressive lethargy for nine days before coming to the hospital. In the last five days before admission the patient vomited twice.

Examination: The pigmentation over the right side of the face, neck and shoulder was unchanged (Figure 2). There was considerable hair covering the pigmented area, particularly over the jaw. Many "cafe-au-lait" spots were also noted over the entire body, more being found on the trunk than on the extremities. A slight droop of the right shoulder was still present. He also had a slight scoliosis to the left in the upper thoracic spine and pes cavus of both feet. The remainder of the general physical examination was within normal limits.

Neurological Examination: There was bilateral papilledema, possibly more marked on the left. The remainder of the examination was normal except for marked lethargy. He could be aroused easily from this, and seemed oriented and rational, but he fell asleep whenever he was left alone.

On January 10, 1951 an electroencephalogram was made.

Dr. White: The electroencephalogram of a child is normally expected to show a good deal of slowing as compared with an adult record. However, this record showed more slowing than can be expected at the age of 11 years. This disturbance was rhythmic, synchronous and somewhat slow. The changes suggested something

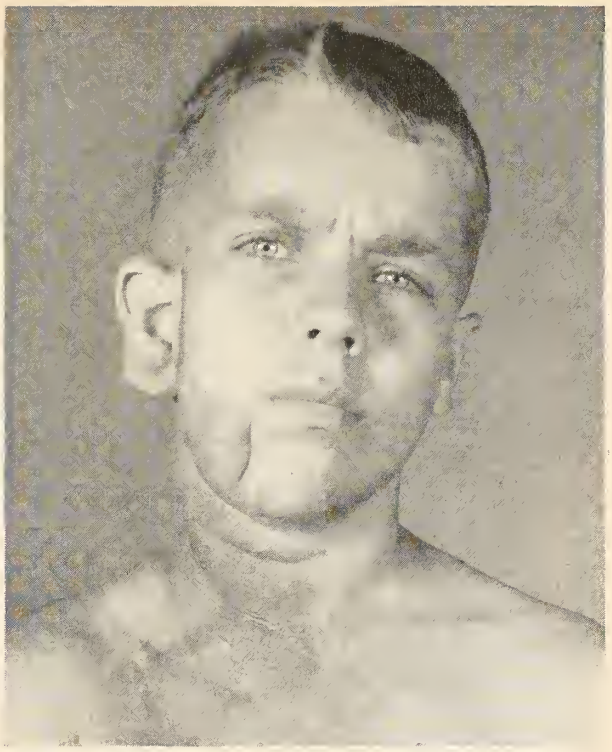

Figure 2. Photograph of patient at age 11 years, showing cutaneous lesion.

being projected to both sides from a mid-line lesion. If this patient had a tumor, we would assume that it was a mid-line lesion. The changes are non-specific and could be seen in a variety of conditions.

Dr. Bickford: I agree that the changes are bilateral. With the clinical data suggesting raised intercranial pressure, these EEG changes would place the presumed tumor near the midline.

Dr. Robert Campbell: The patient was seen by the Ophthalmology Department. One and one-half diopters of papilledema were found on the right, and two diopters on the left. Examination of the peripheral visual fields showed tunnel vision. The Otolaryngology Department found diminished hearing in the right ear which they attributed to changes in the skin of the external auditory canal. Tests of vestibular function were normal.

Dr. Buchanan: The story given is of a boy who comes to the hospital when he is 3 and 6/12 years old. He has trouble with his right clavicle, and he has in addition a birthmark covering the right side of his face and extending down over the right shoulder. From the photographs which are not colored, this birthmark appears to be brown. It is not red, as is usual with the Sturge-

Kalischer syndrome. The second x-ray photograph was of the chest. There appeared to be a shadow in the right upper mediastinum and erosion of the right side of the spine in the upper thoracic region. If these defects are present, they would be additional evidence of generalized neurofibromatosis, and specifically would be evidence of a neurofibroma in the right upper mediastinum. In the history it is said that the boy has high arches in his feet and shortening of both *tendo achillis*. Whether these defects were present at birth or have come in the last year is not stated in the history. They may, of course, be evidence of another congenital abnormality, myelodysplasia. We know that the boy has a defect in the bone of the right clavicle and that he has a brown nævus in the right trigeminal distribution spreading down over the right shoulder. He may have a tumor of the right mediastinum and may have erosion of the spine in the upper dorsal region on the right side. Whether or not the last two defects are present, the diagnosis of neurofibromatosis with the Sturge-Kalischer syndrome would appear proper. The comprehensive title of the diagnosis would be the phacomatoses. The question at this point is, "Does he have a tumor in the right upper mediastinum?"

The papilledema should be the result of an intracranial tumor, part of the whole picture of phacomatoses. Because the external signs are on the right side of his body, it would be probable but not essential that the intracranial lesion is also in the right occipital or right parietal region. It would be expected that this was a congenital vascular abnormality.

Dr. Peterson: In the chest film, there is a dense area with vague margins which would fit well with increased thickness of the soft tissue overlying the chest. It does not have the sharp conformation of a neurofibroma in the mediastinum.

In a film taken five months later, there is a somewhat peculiar appearing cervical spine. His head is turned to give a slightly twisted view, but the spinal canal looks wide all the way up. Even if it is wide, there may be a widening of the spinal canal in neurofibromatosis without any lesion in the canal. You do not have to have tumors within the canal to widen it in patients who have neurofibromatosis. The patient appears to have only six cervical vertebrae, which would be an anomaly, and the laminae seem also to be a little abnormal. It might all be a developmental anomaly rather than a local tumor producing change in the bone. There is no good evidence for a mass in the superior mediastinum. The top rib is denser than the other ribs, which is a peculiar change probably also related to neurofibromatosis. The vertebral end of the rib is thick and dense, but does not show signs of erosion. The right clavicle has been resected. The spine and the pedicles in the thoracic region are nearly normal. There is no enlargement of intervertebral foramina or bone erosion on the right side. Two years later, with the graft in place, there is a fairly good-looking piece of bone which subsequently disappears. A film of the lower end of the femur shows a little area of rarefaction in the cortex. Defects like that in the cortex of long bones occur in neurofibromatosis. Perhaps there are little neurofibromata in the nerves of the periosteum or small fibrotic areas in the cortex.

Dr. Buchanan: From the description given, the patient has no neurological signs except bilateral papilledema. It is said that the papilledema was greater on the left side than on the right, but this is probably of no significance. It would be expected that the assumed vascular abnormality which is intracranial is more on the right side than on the left. Since there is no description given of any weakness on the left side of his body, and there is no history of generalized or one sided convulsions, it could be assumed that the vascular abnormality was not in the parietal region but deep in the occipital lobe. Against this is the absence of any description of defect in the visual fields. It may well be, however, that these could not be properly examined.

Dr. Peterson: In plain lateral skull films made in 1951, there is a defect or hole in the back of the skull on the right side in the occipito-parieto-temporal area. This is a perfectly smooth, round hole. In the AP view it is shown far out on the right side, and there is a very large anomolous Wormian bone, which is practically all on the right side also (Figure 3). Perhaps it is part of this developmental anomaly, too, rather than the result of pressure from an underlying mass.

Dr. Peyton: Do the cranial sutures show any evidence of separation?

Dr. Peterson: The sagittal suture may be a little wider than usual in an eleven year old child.

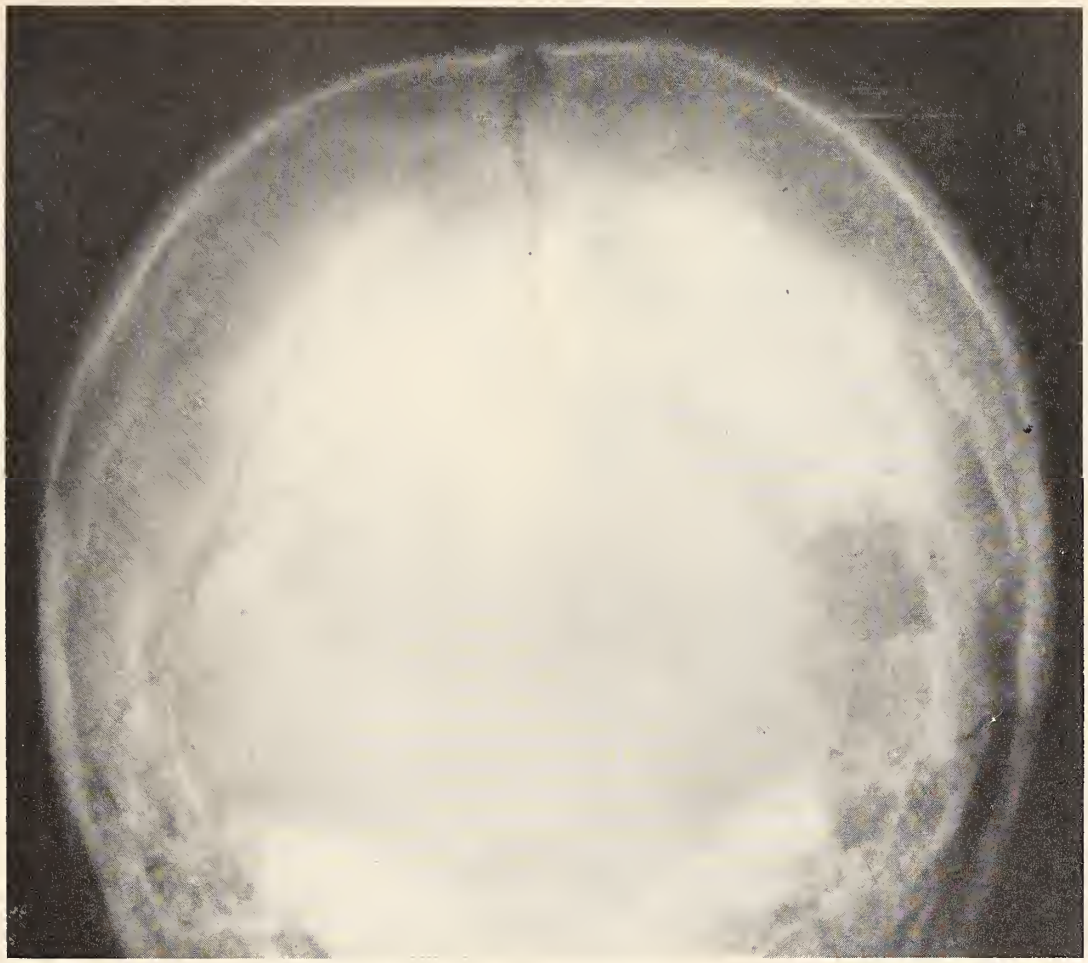

Figure 3. X-ray of skull (plain film) before operation.

Dr. Smith: Dr. Bucy, do you think there is separation of the sutures?

Dr. Bucy: Minimal, I think, and only of the sagittal, as Dr. Peterson pointed out. Perhaps Dr. Peterson is going to comment on the sella turcica.

Dr. Peterson: The sella turcica is not enlarged. The top of the dorsum sellae is a little thin and decalcified, but all the skull bones are a little rarefied. I believe that the sella is within normal limits.

My impression now is that the patient has neurofibromatosis. There are lesions in the femora with the multiple anatomical changes which occur in neurofibromatosis. The lesion in the clavicle is a queer one, as is this defect in the skull.

Dr. Buchanan: The most specific diagnosis which I could give at the present time is that this boy has external neurofibromatosis, the Sturge-Kalischer syndrome, and a related vascular abnormality within the skull on the right side. It would be expected that the microscopic diagnosis of the intracranial abnormality would be part of this whole picture of phacomatoses.

Dr. Bucy: With neurofibromatosis there are a number of possibilities so far as an intracranial lesion is concerned. The thing one thinks of first is a glioma of the optic nerves and chiasm. Such a lesion could obstruct the third ventricle and give rise to increased intracranial pressure. It is most unlikely that that is the case here. Apparently the child has perfectly normal vision, and normal visual fields. A glioma of the optic nerves and chiasm would usually lead to defects in either visual acuity or fields. There have been no x-ray views of the optic foramina, but they probably were not taken because the vision was normal. Dr. Peterson has commented on the fact that the internal auditory meati are normal. Occasionally one sees bilateral acoustic neuromas in people who have neurofibromatosis. Presumably this boy's hearing is normal, and the neurological examination is negative, apart from the signs of increased intracranial pressure, as is the x-ray. I think we can exclude acoustic neuri-

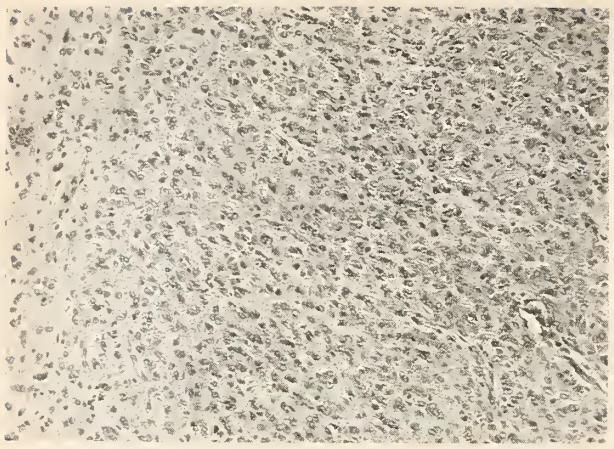

Figure 4. Photomicrograph of tumor in third ventricle. H & E stain, low power magnification.

noma as a possibility. Sometimes we see gliomatous development, particularly in the cerebellum, in connection with neurofibromatosis. We have no cerebellar signs, but cerebellar tumors develop without cerebellar signs on occasion, and that possibility I think is not excluded. But the fact is that neurofibromatosis can be associated with many different kinds of tumors of the nervous system—meningioma, neuromas of the peripheral nerve, gliomas of the central nervous tissue. We will have to have further evidence before a diagnosis can be made and treatment undertaken.

Dr. Peterson: In the ventriculogram, there is no evidence of tumor in the anterior part of the third ventricle, but the region through the mid-brain and cerebellum is still a mystery. The localization of mid-line lesions can be a very difficult problem. If the third ventricle appears all right, the tumor is not there, but one does not know whether it is in the mid-brain or cerebellum if the fourth ventricle fails to fill with gas.

Dr. Buchanan: All that can be said at present from the air studies is that no air has reached the posterior fossa. It is not possible to know whether this obstruction is at the lower end of the aqueduct or at the upper end of the fourth ventricle. The only localization which is possible is that something has obstructed the aqueduct of Sylvius.

Dr. Robert Campbell: After the ventriculogram, a right frontal craniotomy and third ventriculostomy were done. When the anterior portion of the third ventricle was opened, it was found to be larger than normal. This allowed a search of its walls. No neoplasm was seen. Following this operation, the patient did quite well. He was awake and talking the evening of surgery, and he said that his severe preoperative headache had subsided. By the time of his discharge on January 31, 1951, his papilledema had subsided, and he had no recurrence of headache.

The patient was readmitted on February 17, 1951, and on February 20 a right parietal craniotomy was carried out. The flap was made well toward the mid-line, so that the interhemispheric sulcus could be entered. The parietal lobe was retracted laterally, and the posterior portion of the corpus callosum was divided. Through this route, the posterior position of the third ventricle and the region of the pineal gland was exposed. After the incision in the corpus callosum was completed, cerebrospinal fluid flowed out, and then a small piece of yellowish tissue 5 x 8 x 3 mm. This tissue appeared to be attached to the roof of the third ventricle, and was removed for histologic study. Exploration of the area revealed no further abnormal tissue. After this procedure the patient did well again. He was able to recognize his parents the evening of surgery, and was using sentences the following day. He was unable to move his eyes upward on the first postoperative day, but this abnormality could not be demonstrated thereafter. He had a low grade fever until the fifth postoperative day. He released from the hospital on March 2, 1951 without demonstrable neurological deficit.

Dr. Zimmerman: At first, it seemed that the tissue from the third ventricle represented a pineal body. There is a small structure which is concentric, and which is obvious calcium deposition. This normally, of course, occurs in the pineal. We could not find any true pineal glandular structure here. On closer inspection there is a rather cellular structure with a marked interstitial fibrillary stroma (Figure 4). These fibrils are rather medium in thickness and do not represent nerve fibers or mesenchymal connective tissue. They are glial fibers, and these cells which are multipolar, represent astrocytes. It is my opinion that we are dealing with a small glioma of an astrocytic type. I think there is another slide, that shows essentially the same appearance. Dr. Orville Bailey called my attention to the fact that, in certain areas, there is a pseudo-rosette formation, and for a moment we thought it might look glandular and possibly represent a pineal teratoma, if you will. But on closer inspection, these pseudo-rosettes are not true rosettes and the entire structure represents a small

gliogenous, benign tumor of the astrocytic variety.

Dr. Smith: Later, the patient was brought in for some plastic work on the face. A section of the skin showed some hyperpigmentation of the basal cells and also neurofibromatous tissue, along with some lobules of fat.

Dr. Zimmerman: The skin lesion represents a fairly classical neurofibromatosis. In common with Dr. Buchanan, when I read the history and didn't have all the data available, I felt that we were dealing with neurofibromatosis and some form of intracranial lesion that is commonly associated with neurofibromatosis. Without knowing what the skin sections would actually show histologically, I even thought of the possibilities that we might be dealing in part of this skin lesion with an adenoma sebaceum. Having seen one or two instances of peripheral neurofibromatosis in association with tuberous sclerosis of the brain, I thought this might be another. I have seen a number of so-called central neurofibromatoses in which structures very similar to those in the peripheral nerves are found within the brain, especially in the pons and mid-brain, with encroachment and obstruction of the aqueduct of Sylvius. Dr. Bucy mentioned the fact that a glioma might appear almost anywhere. We have ended up here actually with a tumor in or about the pineal region with apparent encroachment upon the aqueduct by pressure. It seems a good possibility, although this has not been proven, that the pineal glioma which we saw here could have compressed the aqueduct of Sylvius and produced the defects in the roentgenograms. We thought of one other possibility before we knew what the lesion was—the vascular tumor which Dr. Buchanan indicated we might find. Vascular malformations sometimes involve the pia-arachnoid and extend into the cerebral cortex, usually on the same side as the malformation of the skin of the face. Thus we end up with a slowly growing gliogenous tumor in association with peripheral neurofibromatosis.

Dr. Peyton: It was not quite clear to me just how you happened to find this lesion. I would perhaps have looked at the posterior fossa instead of at the third ventricle. This is a beautiful result in that you have been able to remove the obstruction and have the patient remain well for a long time. Children with neurofibromatosis are apt to have many anomalies. Why could not one have a narrow aqueduct with a little glial proliferation which was now beginning to give him trouble.

Mr. Pennybacker: Had I been faced with the problem as Dr. Heimburger was, I would have settled for the relief of symptoms after third ventriculostomy. Could you tell us more precisely what the location of the tumor was?

Dr. Heimburger: The tumor was in the area of the pineal gland. In examining the ventriculograms before surgery, we saw a projection into the posterior portion of the third ventricle (Figure 5). This indicated to us the presence of the tumor. At the time, we wanted to relieve the increased intracranial pressure and also, if possible, to do something more specific with the tumor itself. In reviewing the literature, we found that there are reported patients with neurofibromatosis who have meningiomas in the area of the superior medullary velum. I realized that meningiomas in this area are quite rare but apparently they do occur in patients with neurofibromatosis. We approached the posterior third ventricle hoping to find such a lesion. The small piece of tissue described was all that we were able to remove. We fortunately did not get into any difficult bleeding from the friable plexus of veins around the pineal gland.

Dr. Peterson: I have made similar diagnoses; Dr. Peyton has operated and found nothing. We are not keen about these little shadows in back of the third ventricle. They have to be better than this one to warrant a positive diagnosis.

Dr. Bucy: The third ventriculostomy was a lifesaving measure. Operations in the region of the pineal gland are dangerous, with a high mortality. If Dr. Heimburger had attacked this tumor without the shunting procedure, he would have gotten enough edema or hemorrhage into the surrounding tissues to have produced severe obstruction of the aqueduct of Sylvius. This patient probably would have died postoperatively. I think that the third ventriculostomy followed by an interval of three weeks, to allow the patient to get into good condition before reoperating, was an ideal way to handle this situation.

Dr. Heimburger: The patient has done well in high school and has participated in some sports.

Dr. Bucy: The headaches and visual symptoms have subsided?

Dr. Heimburger: Yes. He gets tired rather easily, but this does not interfere with his school work.

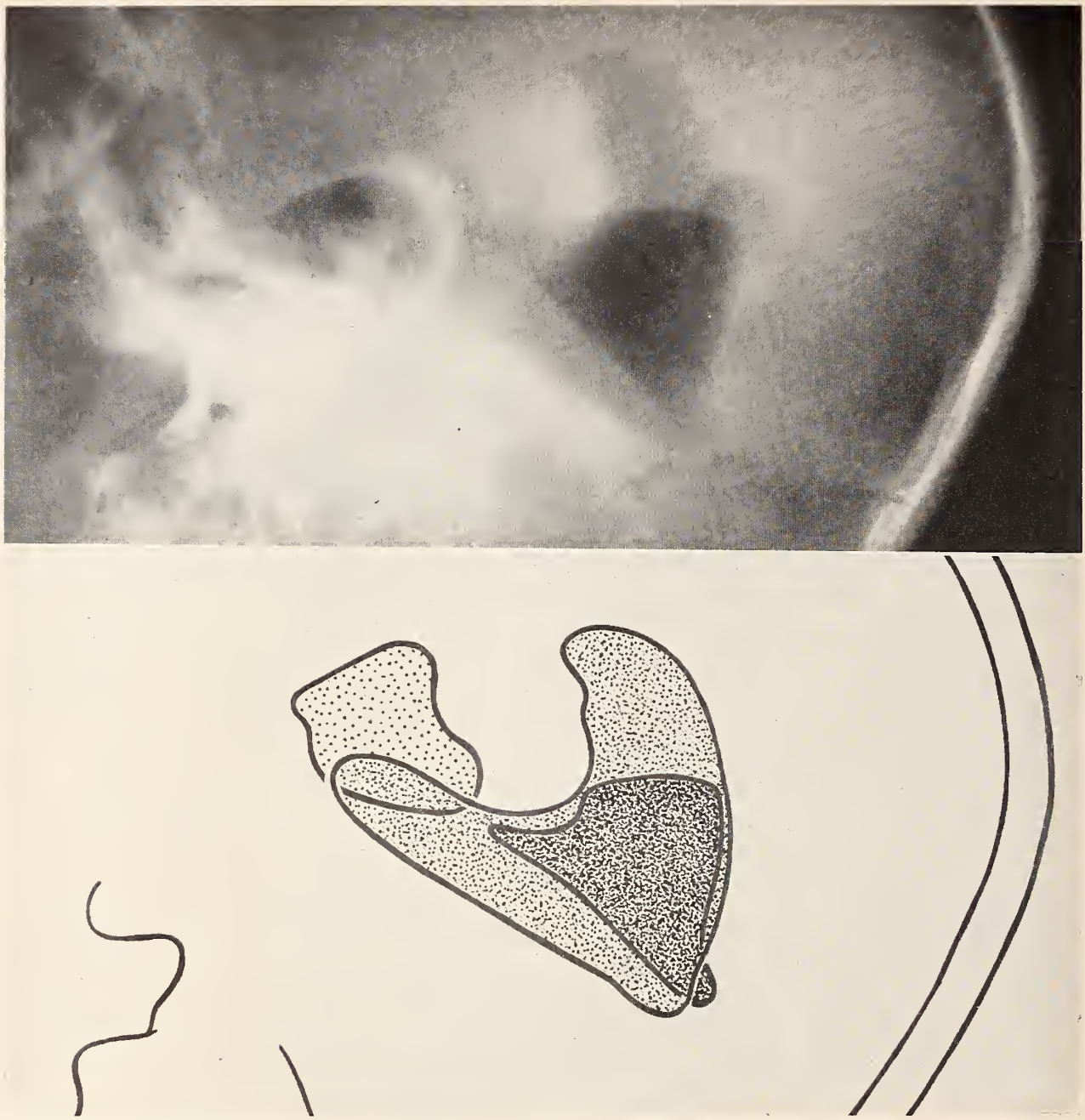

Figure 5. Ventriculogram to show filling defect in third ventricle.

Dr. Robert Campbell: I would like to ask Dr. Zimmerman if the pathological picture follows the pattern of lesions found in tuberous sclerosis, showing astrocytic proliferation rather than a true glioma.

Dr. Zimmerman: The only way we can really make a diagnosis of tuberous sclerosis is to find abnormally placed glial cells or glial cells which are abnormal in size, shape and configuration. Frequently in tuberous sclerosis, elements other than glia participate. Ganglion cells are also found, for example. In this particular lesion, there is no malformation as to size of the astrocytes. They are not the giant astrocytes, for example, that one finds in tuberous sclerosis. There is active proliferation, such as is seen in a relatively fibrous astrocytoma. It is not a very rapidly growing type of tumor. Some people consider this type of astrocytoma in the nature of a malformation rather than a true neoplasm. But I think that according to the present method of classifying tumors, it has to be called a glioma of the astrocytic type rather than a malformation like tuberous sclerosis.

Dr. Peyton: I wonder if postoperative x-rays have been made to follow up the questionably separated sutures?

Dr. John Campbell: I did not think they were separated in the first place. They looked about the same after operation as before.

The Past Is Still Present

A. L. MARSHALL, JR., M.D.

Indianapolis

WITH THE ADVENT of each new immunizing biological, we have witnessed an era where the public and profession have acclaimed the "conquest" of another of man's plagues. Once the successful use of the biological has been noted, a spell of complacency on the part of all has lulled us into a false sense of security. This complacent apathy has been repeated in the last year in regard to the usage of poliomyelitis vaccine. In addition, we have witnessed an increase of diphtheria; pertussis has still killed babies; and the number of known deaths from tetanus in Indiana in 1956 lacked by one death equaling the total deaths from tetanus reported among all of our Armed Forces during five years of World War II. No, history does not repeat itself; the past is still with us!

DIPHTHERIA 1956

	Indiana		*LaPorte County*	
	Cases	*Percent*	*Cases*	*Percent*
Total Cases	91	100%	52	100%
2 mo.—6 yrs. of age	26	28.5	21	40
7 yrs.—12 yrs. of age	23	25	14	26.9
13 yrs.—63 yrs. of age	42	46	17	32.7

Nationally, a rise in incidence of reported diphtheria cases that began in the fall of 1955 and carried over into spring of 1956 was noted. The total reported cases in 1956 was lower in the United States than for the year 1955, *but* the distribution of cases is significant. Instead of widely separated cases, those in 1956 were localized epidemics; such as occurred in LaPorte County in the vicinity of Michigan City.

Several startling facts are apparent in the table of reported cases. Serious consideration should be given these data by physicians and citizens in planning programs to prevent occurrence of epidemics in other communities of the state. Some of the more important facts are:

1. School immunization programs do not entirely answer the problem. In the Michigan City area 40% of the cases occurred in children below school age. Obviously, serious planning must be done to immunize children at an early age before they go to school and not send them to school to be immunized.

2. The smallest percentage of reported cases in Michigan City and the state occurred in children of school age—grade school and junior high school. Though not shown in the table, only 4 cases occurred age 13 to 19 in Michigan City, and 15 cases of the same age group in the state. The age of 19 years would carry the average case beyond high school age.

3. Following a trend noted nationally, 46% of cases reported in the state were age 13 or over — the oldest reported being 63 years of age. This was only slightly lower in LaPorte County. It has been accepted practice for several years not to give booster doses of diphtheria toxoid beyond age 10 or 11 because of the frequency of toxoid reactions. Research by Edsall *et al,* has proven that only minute doses of toxoid are required for initial or recall immunization during adult life.

The Armed Services of this country, Great Britain, and Canada have been concerned enough about diphtheria in adults that they have been giving all personnel combined tetanus-diphtheria toxoid for the last two years.

TETANUS

There were 10 reported cases in Indiana in 1956. Undoubtedly, there were others not known. The total of 10 cases is only 2 short of the figures for the entire Armed Forces of the United States for the five years of warfare in World War II. The final mortality figures are not yet available, but at this time it is known that at least 4 deaths occurred in 1956. In this mechanical age everyone to some degree runs the hazard daily of personal injury and concurrent tetanus infection.

PERTUSSIS

Whooping cough is still a killer of infants. The tabulation is not available for the entire year, but three deaths were known as of September 30, 1956. This disease is poorly reported but occurs in every community.

SMALLPOX

The level of immunity is dangerously low. Immune responses vary with individuals and individuals immunized only one to two years ago might contract smallpox if exposed to a virulent strain of virus. This was dramatically shown among our occupation troops in Japan in 1945-46. The majority of our population is immunized at age six years when they enter school. Unless they serve in the Armed Forces, they then go for the rest of their lives without reimmunization.

SUMMARY

The status of immunization to these diseases for which we have preventive means is dangerously low. To prevent an epidemic, at least seven out of ten people must have adequate immunity. Adequate immunity levels can only be achieved by strong immunization programs in the community. We must literally think of immunization as being a program to follow "from the cradle to the grave." The American Academy of Pediatrics Infectious Disease Committee took cognizance of the problems associated with infancy and the growing child by their programs of immunization beginning at one month of age. (See "Disease Prevention by Immunization and Chemotherapy," p. 870, Vol. 49, No. 7, The JOURNAL of the Indiana State Medical Association, July 1956.

Immunization programs during an epidemic are of value in finally terminating an epidemic. It should be remembered by physicians and the public should be educated, however, that immune responses to immunization do not occur with the insertion of the needle. For example, it takes three to four months following diphtheria immunization before adequate antibody formation has occurred. Last, but not least, consideration must be given to booster immunizations against diphtheria, tetanus and smallpox. By concerted effort of all concerned, we can really make these diseases of the past!

Approved by *Committee on Venereal and Communicable Diseases, Indiana State Medical Association.*

The Journal
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Devoted to the interests of the medical profession of Indiana

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PESTICIDES AND SAFETY

ONE OF THE LONGEST and toughest wars on record is the struggle for survival between the human race and the insect population of the world.

At the present time the box-score on this war indicates no better than a stalemate. This is serious, since one of the main offensive actions of the insect world is directed toward destroying our food supply. Our defense against food destroying insects is costly and time-consuming, and involves much careful work and planning, because the chemicals which we use against the insect pests are harmful to humans if improperly used, or if the foods are excessively contaminated by them.

As good as the American diet is, it is still short of ideal, and to mention one item, it should contain more of vitamins A and C. These vitamins are produced in crops which cannot be raised without the help of pesticides. Of the more than 80,000 insect pests in the United States, about 7,000 are injurious to crops. Over 80 high vitamin crops require the use of agricultural chemicals for successful production.

Insects prevent the raising of or destroy many billions of dollars worth of food each year. Since weeds are a serious handicap to agriculture, and since they also may be controlled by chemicals, it is convenient to include them in a discussion of insects and pesticides. Weeds are responsible for the loss of several billions of dollars in productivity annually.

Chemicals which control insects and weeds are safe for humans if they are properly used. Some of them are toxic if residues remaining on the food are above safe tolerance levels. Protection against hazards of misuse and unsafe residues is afforded by actions of the chemical manufacturers, by the federal law, and by the medical profession.

The National Agricultural Chemicals Association spends more than ten million dollars each year on research. A large share of this research budget is devoted to checking the safety of pesti-

cides before they are offered for sale. A continuing educational campaign is maintained to assure that the chemicals are properly and safely employed by farmers. A recent special issue of the Association's news bulletin was devoted entirely to safety and health.

New compounds are being developed to counteract new insect pests or to deal with vigorous outbreaks of old pests. Some four or five years work and up to one and one-half million dollars are expended on each new chemical compound. About 45 percent of the development cost goes for safety tests.

Public Law 518 is an amendment to the Food, Drug and Cosmetic Act, written by Congressman from Nebraska, A. L. Miller, M.D. This law requires the pre-testing of agricultural chemicals, and as a result of the law, a large amount of research has been done on the chemical residues on foods. Safe tolerance levels have been determined and the foodstuffs are checked to be sure they are safe.

The Committee on Pesticides of the A.M.A. issued a report on organic phosphorous pesticides in 1950, and with the A.M.A. Council on Rural Health is launching an educational campaign to warn the public of their dangers, and to teach proper usage. The Council is asking agricultural organizations to seek the guidance of state medical associations.

The Council is also asking individual physicians to familiarize themselves with the insecticides and their dangers, and to work with county agricultural agents in local safety campaigns. The organic phosphorous compounds are of especial importance because they are comparatively new and because they are being used in increasing amounts. Improper use of this type of insecticide can result fatally, but prompt and proper medical treatment can be lifesaving in cases of near lethal exposure.

MEDICAL NEWS FOR THE PUBLIC

THE RECENT GROWTH in the public's interest in medical information has been phenomenal. All the media of mass communication have recognized this interest and have responded to it. Today practically every newspaper, almost every issue of each of the popular magazines, and each day's program of radio and television contain one or more medically inspired offerings.

All this has imposed a serious responsibility upon the medical profession and upon its allied professions. The pharmaceutical industry has been one of the first to join hands with medicine in working toward a program of beneficial public information on medical matters.

Last year the Health News Institute was formed by the pharmaceutical manufacturers for the purpose of supplying ethical and suitable news releases for the press. Physicians serve on its interprofessional liaison committee.

At the last meeting of the House of Delegates, the American Medical Association established a liaison committee to meet with representatives of the pharmaceutical industry to discuss matters of mutual interest, including the subject of public information.

On March 4 the Maricopa County Medical Society of Phoenix, Arizona was addressed by Henry S. McNeil, President of McNeil Laboratories, on the subject of medical communications.

Mr. McNeil cited the federal government's expanding medical research program, the changing attitude of major professional associations toward public information, the large number of lay organizations devoted to single diseases, and the tremendous increase of health insurance, as factors which have contributed to the public's capacity for absorbing medical information.

He stressed that while the present epidemic of health information had made people more conscious of the factors in good health, it had also created problems involving the need for closer cooperation between the medical profession and the pharmaceutical industry in order to adequately supervise and direct public medical information.

Mr. McNeil outlined some of the steps which

should be emphasized in the effort to control and direct informational services to the advantage of the public. He urged greater effort to keep medical news under the supervision of the profession, and emphasized the importance of close cooperation between pharmacists, manufacturers, hospital personnel and physicians in this field.

He also pointed out that the focus of public interest should be on health problems and health needs, rather than on specific products. He advocated that advertising on "prescription only" drugs should be restricted to the medical profession.

He concluded by saying that if public medical communications are "handled responsibly and intelligently by the medical profession and the pharmaceutical industry, these should result in a better balance between an increasingly knowledgeable public and a medical profession and pharmaceutical industry dedicated to keeping people well."

Guest Editorials:

TENNESSEE MIGHT ADVISE

AMONG THE PROBLEMS facing administrators of Public Welfare funds are certain medical ones which often are difficult of resolution on a local level. It is surprising that this great disbursement of funds which has run into the millions of dollars over the years has had such inadequate medical assistance.

Now it appears that the Indiana State Medical Association has made a recommendation to the Social Security Administration relative to this subject.[1] It is also said that the A.M.A. Board of Trustees has a similar recommendation under study.

It seems that the Indiana plan would consist of the establishment of "district or county committees of physicians to review individual doctors' medical findings under the new law providing O.A.S.I. payments to disabled at age 50." Such a committee would review the physician's report, would carry out further examinations if necessary, arrive at a final decision and would decide whether rehabilitative measures would reverse the disability. The Indiana proposal "would (a) afford an unbiased medical review of the case, (b) remove family and possibly political pressure from the physician, and (c) provide the state agency with a more factual and comprehensive report than it would otherwise obtain, 'which should be of great assistance in making the final determinations as to disability payments.' "

The Tennessee Department of Public Welfare has had a half dozen years experience in requesting cooperation of the medical profession in the administration of its affairs which bear on medical problems. Though some aspects of the Aid to Dependent Children program date as far back as 1910, the Federal Social Security Act of 1935 provided for the matching of federal funds by states for public assistance to: (1) needy persons over 65 years of age; (2) the needy blind; (3) needy children who are deprived of parental support by reason of death, absence from the home, or the physical or mental disability of the parent. In 1937 Tennessee passed the legislation to participate in these programs. From the time of enactment of the A.D.C. Act in 1937, until 1950, assistance to children was given on certification of disability of the wage-earner by a physician. In June, 1950, the Department of Public Welfare began to provide for more complete medical examinations to determine disability. In August, 1951, the Department chose a part-time Medical Consultant, an internist, to assist in the A.D.C. program. This Consultant with members of the Department began an analysis of the medical problems related to A.D.C.

As a result of this experience the Commis-

[1] A.M.A. Washington Letter (84-103) Dec. 28, 1956.

sioner of Public Welfare formed a State Advisory Committee to the Department. Dr. Ernest Kelly, then president of the T.S.M.A., appointed three members of the State Association who, with a representative of the Vocational Rehabilitation Division and Employment Security, made up the Committee. It met first in April, 1952. It recommended formation of a Medical Review Board which was selected from a panel of the profession submitted by the Nashville Academy of Medicine—two internists, one general and one orthopedic surgeon.

The accomplishments of the early months of this Medical Review Board have been published.[2] The A.D.C. case load in September, 1950, was 25,902 families with a monthly cost of $1,238,-112.00. Of these cases, disability was the cause of deprivation of parental support in 48 per cent (12,433 families) of the total case load.

In reporting to the House of Delegates in 1955,[3] the Committee reported that the Medical Review Board had reviewed 7,602 A.D.C. cases and 2,788 Aid to the Disabled Cases. Of the A.D.C. cases 67 per cent were approved for disability. As of February, 1955, 5,874 families were receiving A.D.C. grants due to the disability of the breadwinner, at a monthly cost of $384,218.00. (Compare this with the preceding paragraph.) This represented 27 per cent of the total A.D.C. load.

The contribution of the Medical Review Board to the Department of Public Welfare and to the taxpayer has been tremendous. Obviously, the objective of the Medical Review Board is *not* to save money; its objective is to aid in the assistance being given to the *truly disabled* and to urge rehabilitative measures to again make the recipient a productive, self-respecting citizen of the community. Thus, the Board has met the Indiana objective to "(a) afford an unbiased review of the case." Furthermore, it has been a buffer between the local physician and local pressures, meeting the Indiana objective to "(b) remove family and possibly political pressure from the physician." The local doctor may be backed into an untenable corner when the soft-hearted ladies' aid of the church, feeling sorry for an improvident "gold-bricking" father of ten children and having a "backache" which makes work impossible, urges certification of a "disability." Or the improvident diabetic, of better health when active may have their sympathy to place the local doctor under inevitable pressure to get A.D.C. for his children. All of us have seen case after case of this type either in practice or in our hospital clinics.

This is an ever-increasing problem as more and more federal and state funds are poured out in public assistance. The latest assistance to these very same groups was the subject of a recent editorial. An unbiased doctor or group of doctors must be on hand to decide medical problems for the lay administrators who wish to do a good and honest job of disbursing public funds to help the deserving, and at the same time to aim for a self-reliant populace which scorns a panhandler.

The Department of Public Welfare of Tennessee has been a pioneer in seeking advice from the medical profession. It has had a satisfying experience. Let Indiana, the Social Security Administration and the A.M.A. profit from its experience. R. H. K.

(From The Journal of the Tennessee State Medical Association, January 1957).

[2] The Aid to Dependent Children Program. J. Tennessee M.A. 46:104, 1953.

[3] Report of the Liaison Committee to the State Department of Public Welfare, J. Tennessee M.A. 48:177, 1955.

TRANQUILIZING DRUGS

THE widespread usage and publicity given in both non-medical and medical journals to the tranquilizing drugs — Chlorpromazine, Equanil, Atarax, Reserpine—indicates that we are entering into a new era of pharmacotherapy in mental illnesses. In fact, this renaissance is not entirely limited to use of these therapeutic agents in treatment of human illness but there apparently is a rapidly increasing use in veterinary medicine as shown in recent enthusiastic reports of the use

of Plaxitel. The sale of these tranquilizing drugs now is the third largest of the total sale of pharmacological agents used in treatment of illness.

The tranquilizing drugs were administered initially to depressed, apprehensive, fearful, aggressive, noisy, combative, and resistive patients. In short, they are universally used for control of various states of psychomotor agitation, varying from delirious states to agitated depressive states, and for control of disturbed schizophrenic types of psychoses. The use of chlorapromazine (Thorazine) produces a rapid and pronounced change in the general atmosphere of our mental hospitals. Patients begin to eat and sleep better, are calm, agreeable, and sociable and, with associated rehabilitative measures, begin to take an interest in their environment and in life itself. Many lose their confusion, possibly because of decreased activity and increased appetite with a more varied and adequate intake of food. Complaints of pain decrease. The morale and general atmosphere of hospital wards, especially the back wards devoted to disturbed patients, was noticeably improved. Mental hospital administrators began to note pronounced decrease in use of analgesics and sedatives, despite the fact that doses of chlorpromazine are often very small, averaging from 20 to 200 mgm. per day. Many hospitals, for the first time, have reported a decrease in the total census. This is particularly true of the State of New York, and recent reports of extensive use of these drugs in state hospitals of the Rocky Mountain region indicate, for the first time, a drop in the total census of various institutions.

A pleasing sequellæ to use of these drugs has been the stimulation and development of research methods in psychiatry, as well as the equally important, tremendous upsurge in interest, in visiting, and in greater support on the part of the public of mental hospitals. During October, 1956, there was a national conference on the evaluation of pharmacotherapy and mental illness. Congress has recently appropriated $2 million to coordinate drug evaluation and the consensus of opinion has resulted in the following recommendations:

1. That support be provided basic research, launching pilot studies, the development of methodology and coordination of cooperative programs.

2. That increased attention be given to the effect of drugs on behavior and psychologic functioning.

3. That the National Institute of Mental Health seek to improve channels of communication in this and related fields by preparation of annotated biographies, reviews, newsletters and appropriate conferences.

As is true when one is dealing with new drugs and uncontrolled enthusiasm, one may overlook not only serious complications but also the fact that all drugs, more or less, should be looked upon as an improvement of combined therapy in which drug therapy and psychotherapy will be complementary procedures. The complications, although comparatively infrequent and usually reversible, may be most serious. This is especially shown in a rare death from agranulocytosis following administration of chlorpromazine. Also the small percentage of cases which develop skin and liver complications indicate that these drugs should be used only under the strictest supervision of physicians. Many of these drugs actually cause depression of varying degree. A Parkinsonian-like syndrome occasionally may occur and is usually reversible with withdrawal of the drug. Other undesirable side effects, which some of the drugs may produce at times, are stuffiness of the nose, diarrhea, and excessive sleepiness. In spite of these drawbacks, psychiatry, general medicine and surgery welcome these new tools with enthusiasm. One should compliment the excellent attitude of the pharmaceutical firms in their cooperation and scientific research which led to development of these drugs. Our enthusiasm, however, is tempered by the knowlege that there are many aspects of emotional illness which cannot be influenced by even the most skillfully supervised use of the newer tranquilizing drugs. We must use caution combined with careful clinical judgment.

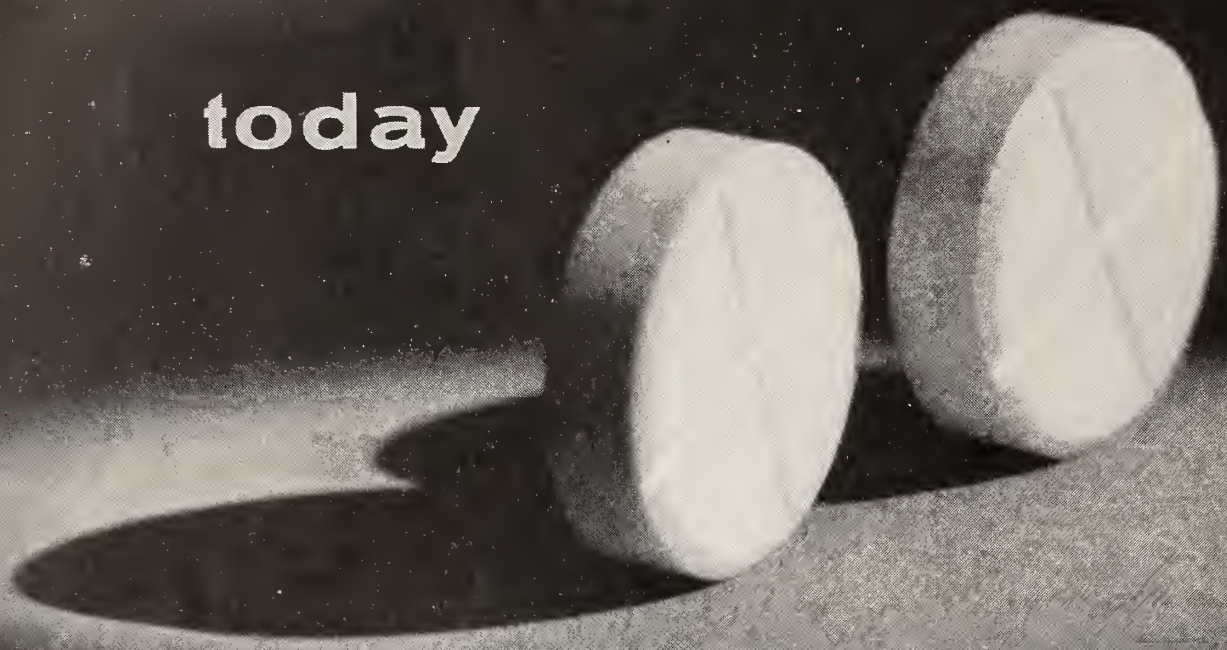
Franklin G. Ebaugh.

(From the Rocky Mountain Medical Journal, December 1956).

tomorrow's sulfa

is here

today



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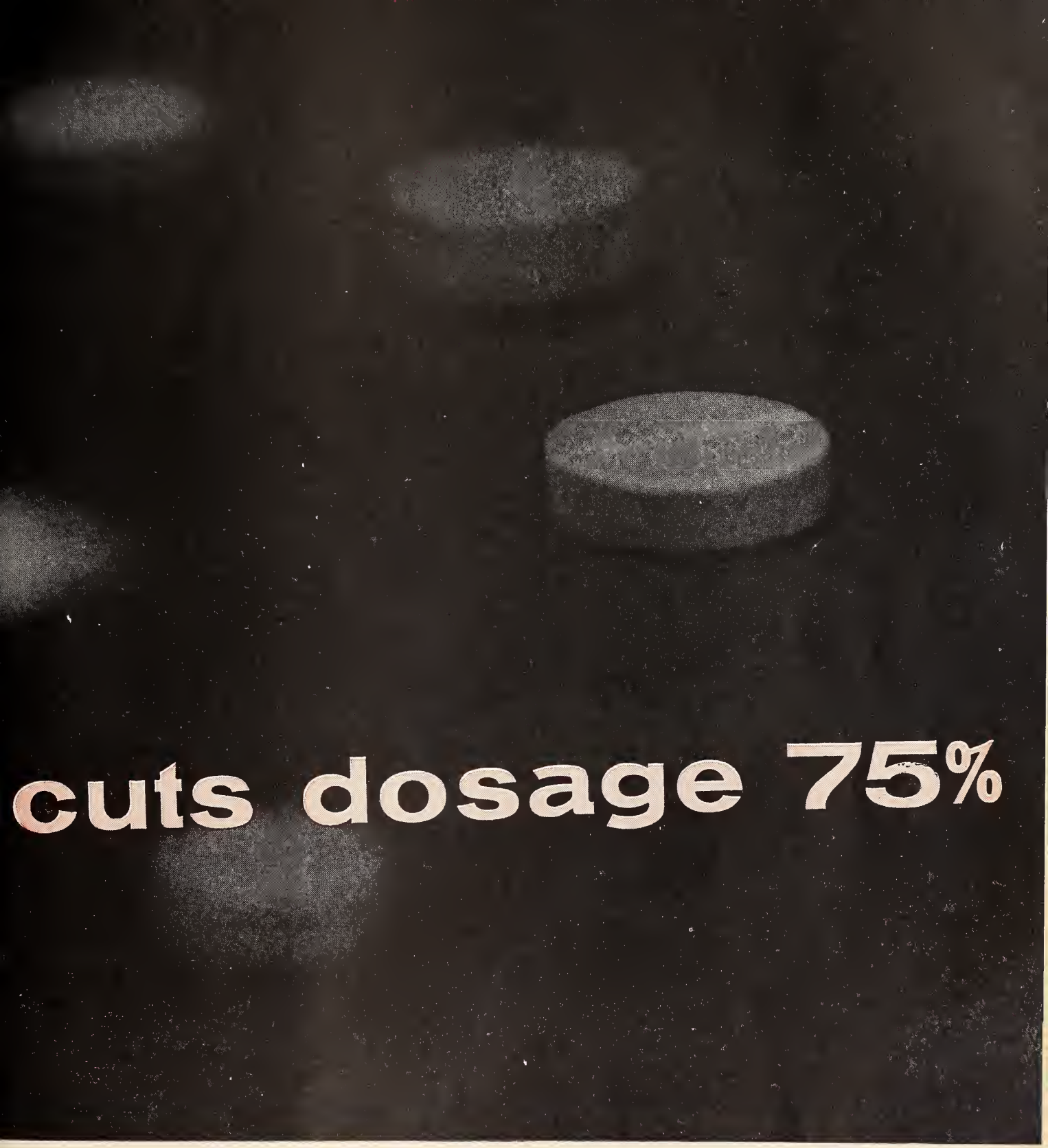

LOW DOSAGE: a total maintenance dose of only 2 tablets daily.

SOLUBILITY: prompt absorption, ready diffusion into body fluid and tissue.

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*REG. U. S. PAT. OFF.

SAFETY: KYNEX offers a margin of clinical safety based on low required dosage, solubility, slow excretion rate. Although KYNEX Sulfamethoxypyridazine is a sulfonamide derivative and the usual precautions regarding such drugs should be observed, the low daily dose of 1.0 Gm. is all that is required for therapeutic blood levels. No increase in dosage is recommended.

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TABLETS: Each contains 0.5 Gm. (7½ grains) sulfamethoxypyridazine. Bottles of 24 and 100.

SYRUP: Each teaspoonful (5 cc.) contains 250 mg. sulfamethoxypyridazine. Bottle of 4 fl. oz.

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK Lederle

The President's Page

POLIO VACCINATION—1957

ENOUGH TIME has elapsed since the first dramatic, and at times almost hysterical, introduction of the Salk vaccine program to begin to assess its value and to know what it will do. There seems no question but that the protection afforded is high, perhaps 85-90%. The American Medical Association is to be congratulated upon their method of handling the plans and publicity this year. This started with the big meeting at the Palmer House in Chicago on January 26, which was presided over by one of the Trustees, Dr. Julian P. Price. At this meeting, plans were formulated and the inspiration given for a really big use of the vaccine. In other words, the drive and control of this huge project was to come through the channels of organized medicine, and not to be imposed upon the doctors because their assistance was needed in the actual giving of the injections. In Indiana, this meeting was followed up by two planning sessions of the Council and appropriate committees held on February 3 and 17.

Now that the control and organization of this work has been entrusted to the medical profession, we should justify this trust and responsibility by making the best possible use of this material. That this approach was a successful one was soon shown by the rapid reduction of vaccine supplies, so that as this is written, in many places no vaccine is available. Part of this fluctuation is due to seasonal demand, and part due to the human trait of wanting something immediately if it appears there may be some difficulty in getting it.

I believe that with the increased experience and the great back-log of successfully immunized children and adults, another polio season will find us ready to take care of the demand for vaccination. At that time, polio vaccination may be put upon the same common sense routine basis that our other immunizations are now on, and not be subjected to the fluctuating surplus and shortage market that has been the case in the past several years.

Perhaps some delay in protection has been occasioned by parents waiting for other or better types of vaccine. There has been some talk of oral vaccine or of combinations with the diphtheria-tetanus-pertussis vaccine with which they are already familiar. No encouragement should be given to this procrastination, as the time for protection is **now**!

Fellow physicians, you have asked for, even demanded, the control of the vaccination program. Let us now show our individual and collective responsibility in its administration. I thank you.

Elton R. Clarke, M.D.

Medical Panorama—

A. W. Cavins, M. D.

Terre Haute

THE SWING OF THE PENDULUM

Indiana has been noted for its interest in education, and early had many small colleges scattered over the state. These provided what has become known as "a liberal education" in contrast to technical and professional schools. With increasing emphasis on science, "liberal education" received less attention, until recently, especially in medical schools (but also even in industry seeking young executive prospects) the lack of solid foundation in "liberal arts" has become a source of concern. It is, therefore, of particular interest to find an article in "Philadelphia Medicine" for February 22, 1957, upon this subject by two members of the Student American Medical Association. In reading this essay please bear in mind that the authors are *students*, not moralizing I-told-you-so's of an ancient generation. Notice that they are completely in touch with present-day problems and, of all things, are particularly concerned with public relations! This from the youngsters! You owe it to yourself and to your **esprit de corps** to read the following:

MEDICINE AND LIBERAL ARTS

Fred Floyd and Jack Lane

It is the physician's duty to uphold the dignity and honor of the medical profession. The reputation of the profession is dependent upon the character of each of its members, for the physician is but one among many.

Yet in the past decade we have witnessed an alarming decline of the public's esteem for the medical doctor. Evidence for this is readily available in many articles currently appearing in the lay press. That the medical profession is aware of this trend is also well seen by its reaction to this attitude.

What is the cause of public reaction? Does the fault lie with the physician? If so, is it the type of therapy he employs or does the cause go deeper, into the type of man himself?

In no article do we find criticism of the physician's weapons against disease. On the contrary, we read praises of the "wonder drugs," marvelous operations and the extensive research now being conducted in many fields.

Public opinion, on the other hand, seems to be directed against that type of doctor who, although in the minority, holds a place of preeminence in the thoughts and talk of our fellow citizens. This is the unsympathetic, materialistic dispenser of physic who practices primarily for his own benefit and convenience and not for the health and welfare of his patients. Undoubtedly we can all recall a similar charge being leveled at one of our profession. Whether justly or unjustly in a particular case, the accumulation of such accusations constitutes a falling barometer, a danger signal both to the profession itself and indirectly to the public.

Having been taught the most modern therapeutics and leaving his medical school with the spirit of Maimonides: "May the love for my art actuate me at all times; may neither avarice, nor miserliness, nor the thirst for glory, nor for a great reputation engage my mind . . .," why should any man return for his tenth reunion as a cynical and supercilious physician who gives the latest scientific treatment but the least sympathetic understanding?

It is our opinion that the fault lies with the training of the doctor. His training tends to channel his thoughts and efforts into a strict scientific deduction of disease processes and pathologic physiology but leaves little room for the development of the Art of Medicine.

Selecting a few courses of English and perhaps a review of History of Philosophy cannot hope to replace the curriculum of the nineteenth century which produced the educated physicians of the day. Those men contributed to literature, to government and to almost every field of learning, far out of all proportion to their number, both in quantity and quality of output.

To be sure, a return to the active study of history, Latin, world politics, economics, and social studies would not constitute a miraculous cure for the profession's troubles, but it would certainly help to elevate the aims of our future doctors to goals and ideals beyond those which many presently see.

The cry may be raised that a thorough knowledge of science is a prerequisite for successful completion of medical school, but is it? How much of our knowledge of qualitative and quantitative analysis, physical chemistry, genetics, comparative anatomy and biochemistry were needed in medical school?

Was not everything taught over again, beginning with

the simplest concepts? And what better argument than those of our number who never had such subjects in undergraduate school and yet, not only have passed, but have done so with admirable grades?

The present problem of the self-centered doctor can, we feel, be traced in a great measure to his lack of true education, and the long-term solution to this dilemma should be sought in leaving the medical school to teach the medical sciences and the undergraduate schools to teach the humanities.

Some of the questions raised are now receiving attention from medical faculties. We await the results with interest and hope. In these days of electric clocks we have lost sight of pendulums, but they do swing. —*A. W. C.*

Past President of ISMA Named Advisor to U.S. Public Health Service

DR. WALTER L. PORTTEUS, past president of the ISMA, has been appointed to a committee of seven physicians to advise the Surgeon General of the U. S. Public Health Service on activities of that service which are related to the practice of medicine.

Dr. Leroy E. Burney, in making the announcement, said: "We have many groups advising us on research and disease control. With growth of medical and related research, it is increasingly important that we work with private physicians as well as health agencies to help apply the new knowledge promptly and effectively. Our new committee will be of great aid in this and in advising on activities of PHS which bear directly or indirectly on the practice of medicine. We are very grateful to have the advice of this distinguished group of physicians."

Members of the committee in addition to Dr. Portteus are: Drs. Hugh H. Hussey, Washington, D. C., and Julian Price, Florence, South Carolina, both trustees of the AMA; Stuart Adler, Albuquerque, New Mexico; C. Byron Blaisdell, Asbury Park, New Jersey, a member of the AMA Committee on Legislation; Stanley R. Truman of Oakland, California, former president of the American Academy of General Practice; and William B. Walsh, Washington, D. C., past president of the National Medical Veterans Society.

The new group held its first meeting in Washington on April 4 and 5.

Hoosier physicians attending the A.M.A. meeting in New York are reminded that the Indiana State Medical Association will maintain a hospitality room in the Headquarters hotel, the Waldorf-Astoria. Members are invited to visit the ISMA headquarters for refreshment and companionship, and to assist in the entertainment of friends from other state associations.

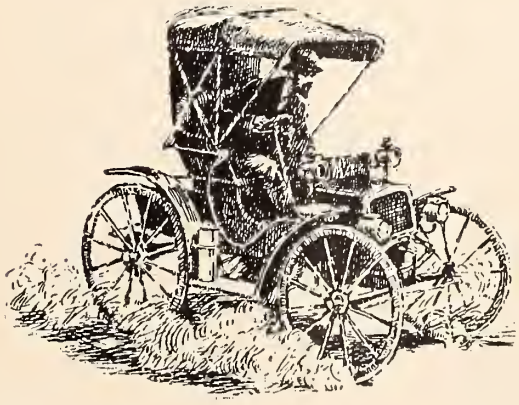
Fifty Years Ago* . . .

I am only one,
But still I am one,
I cannot do everything,
But still I can do something;
And because I cannot do everything
I will not refuse to do the something
that I can do.

—Edward Everett Hale

BECAUSE he wanted to "do the something that he could do" the early physician of Indiana rode horseback to remote farm homes to ease . . . and many times cure . . . the ill and the injured. In 1908, when The Journal first was published, the horseback rider was almost a thing of the past, even in the most isolated areas; the horse and buggy was still a familiar sight in rural communities, but city doctors were driving horseless carriages at unheard-of speeds to reach their patients sooner.

Proof of the rugged life those early physicians led is found in this "Personal Comment" in the June 15, 1908 issue of The Journal: "Dr. W. P. McMillen, of Decatur, had a narrow escape from drowning while on his way to see a patient near Berne Wednesday night, May 6. The night was dark, and when about three miles north of Berne the horse stepped off a bridge into a flooded creek. The buggy followed, and Dr. McMillen was thrown headlong into the stream. By grasping the floating buggy he was able to keep from drowning and finally crawled up the embankment to the road. In due time the horse was rescued, and the Doctor proceeded on his way to the house of his patient, returning home later in a prostrate condition. As a consequence of the accident Dr. McMillen contracted a severe cold and was confined to his bed for several days."



1908 was the year Dr. D. W. Robertson of Deputy read a paper at the Fourth District Medical meeting at North Vernon in which he deplored the lack of sanitary facilities in rural areas and small towns. Speaking of the prevalence of typhoid fever in the country, he said: "Better give money to the hardware dealer for wire screening than to fee the doctor."

And the editor wrote in the April issue: "For the benefit of prospective contributors to The Journal the editor desires to say that it is taken for granted that when a paper is submitted to The Journal it is for exclusive publication in The Journal and is not to appear elsewhere." . . . that policy is still enforced.

At one meeting of the Fort Wayne Medical Society on April 14 case reports were heard on these subjects . . . Tuberculosis of Bladder and Kidneys; Erysipelas; Mongolian Idiot; Detachment of the Retina; Ulceration of the Cornea; Cancer of the Uterus; Tumor of Parotid; Endothelioma; and Cold Abscess of Tubercular Origin.

At an Indianapolis Medical Society meeting

* The Journal was just five months old.

on March 24 there was lengthy discussion of "The Relation of Physicians and Druggists" by Dr. S. E. Earp, and later in the evening Frank H. Carter made a plea for use of the National Formulary and Pharmacopeal preparations. Mr. E. H. Zimmer said the two drugs, castor oil and phenolphthalein, were marketed under 70 different trade names. Others spoke and at the end of the evening it was moved and passed to join the local branch of the American Pharmaceutical Association in a concerted effort to halt over-the-counter prescribing and self-medication as well as the use of untried proprietary products.

Pressure was building up all over the state to change the time of the annual state meeting from early summer to September or October. Proponents of the change said the Indiana meeting was too close to the annual A.M.A. meeting and many doctors could not afford the time and money to attend both meetings.

The membership in the Indiana State Medical Association was reported in June as the largest in the history of the Association, due partly to the work of special AMA canvassers in the state and also to the efforts of THE JOURNAL which had been writing letters and sending out sample copies of the new publication.

Does this sound familiar? A July editorial says: "In his oration on surgery at the Chicago meeting Crile opened up a subject of such interest and import that if his hopes are realized and his apparently well-founded theory becomes a clinical reality, it is difficult to measure the debt of humanity to him and to those who are working along similar lines. By means of a comparatively simple blood test a diagnosis of malignant disease has been established where before it could only be suspected. And in the fight against cancer this has been the one *bete noire* to our success. Radical operation at an early stage of the disease gives a reasonably good prognosis as to cure, but the difficulty lies in making the diagnosis before the lesion has diffused sufficiently to preclude its complete surgical eradication . . ."

And speaking of state conventions . . . the June Editorial Notes queried: "We wonder if Pluto is good for spring fever." —j.s.g.

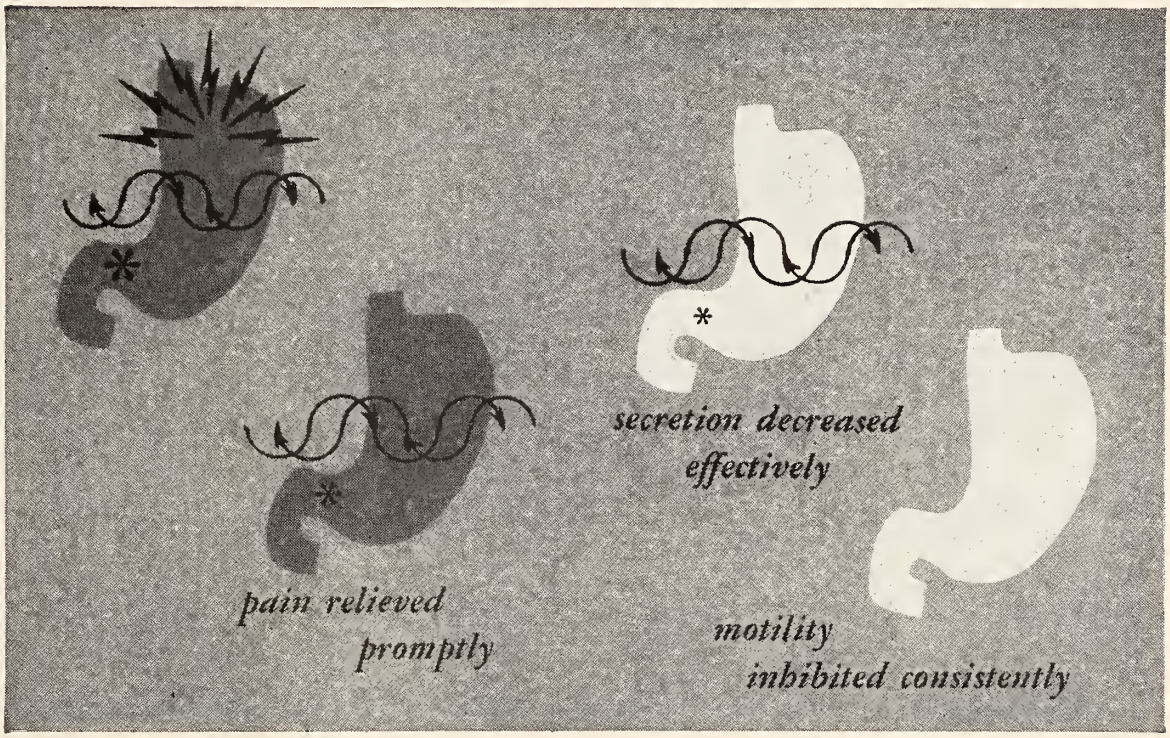
DROP "IN MY DAY"

One of the most challenging citizenship responsibilities we doctors have is the training of succeeding medical generations. Three words that we ought to delete from our discussion are "In my day." We must assume a very definite and personal interest in the social, professional, scientific, cultural, physical and spiritual welfare of our House Officers. We must take them into our homes and let them see how we live and what our philosophy of life is. Enjoying Hi-Fi music together is as important as holding retractors together—or more so. A few hours spent in his chief's private office and living room or hobby shop during a rotating internship may be a most valuable experience for an intern.

—*Philadelphia Medicine.*

CONFIRMED THERAPEUTIC UTILITY

Pro-Banthine®...
A Primary Drug in Peptic Ulcer



Among the many clinical indications for Pro-Banthine (brand of propantheline bromide), peptic ulcer is foremost. During treatment, Pro-Banthine has been shown repeatedly to be a singularly valuable agent when used in conjunction with diet, antacids, sedation and psychotherapy as required. Lichstein and his associates* report that Pro-Banthine "proved almost invariably effective in the relief of ulcer pain, in depressing gastric secretory volume and in inhibiting gastrointestinal motility. The incidence of side effects was minimal. . . ."

The therapeutic utility and effectiveness of Pro-Banthine in the treatment of peptic ulcer are repeatedly confirmed in the medical literature. Dosage: One tablet with each meal and two tablets at bedtime. G. D. Searle & Co., Chicago 80, Illinois, Research in the Service of Medicine.

*Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: Pro-Banthine in the Treatment of Peptic Ulcer. A Clinical Evaluation with Gastric Secretory, Motility and Gastroscopic Studies. Report of 60 cases, Am. J. M. Sc. *232*:156 (Aug.) 1956.

SEARLE

The American Heart Association

EDGAR V. ALLEN, M.D.*

Rochester, Minnesota

LADIES AND GENTLEMEN: It is a great pleasure to speak to you. I know from long experience how important volunteer workers are to the over-all efforts of the American Heart Association. I commend you for your efforts and compliment you on your accomplishments. Without you, the American Heart Association as it is today could not exist. Workers such as are in this audience are the primeval sinews and bones of the American Heart Association. I hope that you who constitute the fundamental strength and security on which the program of the Association must rest will give increasing thought and support to research, education and community service—the only recompense we can make to those who provide us with the funds which we use to carry on our work. With your help, we have lifted our part of the civilized world out of a groove and set it on a plain; we have started a new epoch; nothing can again be as it was before. We are searching for more than anyone before has sought. Our complete story still lies on the horizon's rim.

Part of my subject, research, is so important to me—so important to you—so important to every American—that even some repetition can only be beneficial.

THE MEANING OF RESEARCH

Research is a persistent struggle to find the truth. Medical research seeks to disclose the hidden meaning of life, of health, of disease and of death. If man had emerged from the dark and distant past into the bright industrial and economic present without the salubrious heritage of research in the field of disease, he probably would have emerged ridden by more diseases and infirmities than he could possibly conquer, and it might well have been that they would have vanquished him and his progeny.

As a result of research, countless beneficial substances and procedures are available: penicillin and other antibiotics; insulin for the treatment of diabetes; effective means of preventing acute inflammatory rheumatism; the use of anticoagulants; improved methods of treating high blood pressure; surgical operations on the heart and blood vessels which give promise of even happier achievements to come; vaccination and immunization. Yet these are only a few of the accomplishments of research; I could talk to you for hours on end and still not describe all of them.

If research had not been done, millions who now are healthy adults would have died in infancy; many, many mothers would have died in childbirth, and the average expectancy of life in this country would have been nearer 39 years, as it was a hundred years ago, rather than 70 years, as it is today.

Research is conducted in all fields of medicine and in various surroundings: in the laboratory, at the bedside and in the operating room. Research requires scientific training; the quality of persistence in the face of discouragement; a desire to battle against the unknown; willingness to work without respite, and great impatience with the half-true and the obscure. Research is no profitless enterprise; sometimes it is measured in terms of resources, of tools, of men and of public support which can be mustered in our times. But most of all, however, its gains must be measured by results. As is true of most human endeavor, the quality of research can be good, bad or indifferent, but it is certainly true that where there is no research, there is no progress. No one knows when, from a corner of some laboratory, there will come a basic discovery which, like a

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Presented under the auspices of the Indiana Heart Foundation, Indianapolis, Indiana, January 31, 1957.

* President, American Heart Association and Section of Medicine, Mayo Clinic, Rochester, Minnesota.

brilliant beam of light, will dispel the darkness of ignorance. It is a long way from an idea to success, and the journey does not lead through lassitude and indifference.

The American Heart Association has embarked on a program of research because 800,000 Americans die each year of diseases of the heart and blood vessels, and perhaps 10 millions are afflicted with such diseases. In 1956-1957 the American Heart Association will spend about 6 million dollars for research. That seems a vast sum, but it represents only about a sixth of the expense to American taxpayers for the removal of paper and other rubbish from along the highways. Six million dollars represents a per capita investment in health of only a trifle more than three cents. This observation must be viewed in an economy in which 45 million families earn more than $4,000.00 annualy. The 6 million dollars would buy only 2,000 automobiles. The total of $20,000,000 spent by the American Heart Association and its affiliates in the eight years of our existence represents about two thirds of the amount spent by Americans to feed their parakeets each year. Currently, the total amount spent for industrial research is 5 billion dollars annually. The total annual expenditure for medical research appears to be in the neighborhood of a quarter of a billion dollars; 20 dollars for creature comforts; 1 dollar for health. The program of medical research represents rebellion against physical deterioration, but the rebellion is still so small that it seems to be hardly more than an insurrection. More scientific minds, more buildings and more equipment are urgently needed.

Almost everyone in this audience has had some sorrowful experience with disease of the heart or blood vessels, or both. Each of you, a member of your family, a close personal friend, a neighbor or an associate, almost certainly will have had or does have heart trouble, or he suffers from the effects of a stroke, of failure of the kidneys to work properly or of poor circulation to the legs.

There is, therefore, no need to defend a nation-wide, cohesive, planned attack on diseases of the heart and blood vessels. Rather, every reason exists for extending the attack with vigor. I hope that everyone who gives money to the cause will consider the donation to be an investment, rather than a gift. People in the prime of life are dying in great numbers from diseases of the heart and blood vessels. To prevent these deaths and to give relief to the ill is to protect oneself and one's family. Certainly, this cannot be called a charitable enterprise. Anyone who knows that diseases of the heart and blood vessels kill more people less than 65 years of age than do the next five causes of death combined, cannot doubt that his investment in research will, with the investments of others, go far toward extending either his life span or that of his progeny.

Research, then, has an intimate, significant meaning for almost everyone. It is closer to all of us than most of us realize.

THE ORGANIZATION OF RESEARCH

We cannot fully understand the methodology of research if we do not know how it is to be organized or how it is to be done. For that reason, some attempt at explanation may be useful to you, as it has been instructive to me.

In the beginning, then, must be the definition. The paramount need of the Association is for the inquisitive mind, the explorative mind, the mind that never can be content with the established order of knowledge but is incessantly seeking to add to it.

The possessor of such a mind we regard highly in the parent organization of the American Heart Association, so highly, in fact, that we encourage him to choose what he wishes to investigate. We allow him to go where he can do his work best. We free him, as much as possible, from administrative distractions. We allow him plenty of time in which to prosecute his studies. Finally, we provide him with an income which is sufficient to allow him to do his work in the way I have sketched it.

Categories are useful to all of us. They help us to keep our fingers on the essentials and they exclude the trivial. We have set up simple categories in the research field at the national level to help in understanding the work that is done in investigation and to show the status of those who do it.

Career Investigatorship. A Career Investigator, under our unique definition, is a mature scientist who is assured of lifetime support for his investigations at an income comparing favorably with that of full professorship. We have three Career Investigators now. More will be added. They have the benefit of added funds

for equipment, materials and laboratory workers. We think the category of Career Investigatorship is almost without parallel in the realm of scientific awards.

Established Investigators. We have 75 workers in this category. They are skilled, competent scientists fully qualified to carry out their inquiries independently, and they have a tenure of five years to encourage them to do so. If their work gives evidence of promise, the tenure may be extended for a second five-year term. In some respects this category is comparable to a proving ground, for especially gifted workers may be chosen from it to become Career Investigators.

Research Fellowships. We now have 58 men who are Research Fellows. They are younger men, not yet highly skilled in methods of investigation, who work under the supervision of others who are highly skilled in their fields. The tenure of a Research Fellow is one year or two years. The category actually is one of considerable opportunity and boundless advancement, for it is from this group that the experienced investigators of the future will emerge.

These three categories are indispensable, we think, to the stimulation of younger men so that they will be attracted to scientific investigations in fields which hold the attention of this association.

Grants in Aid. Still another category having to do with research is the Grant-in-Aid. Last year 149 such grants were made. In effect, such a grant sustains the cost of research by placing technical assistance and supplies in the hands of experienced investigators.

This is a good program but not good enough. I hope that in the regional meetings of staffs this year, ways will be found to refresh the springs of research and make them flow in increased quantity.

EFFECTS OF THE RESEARCH PROGRAM

It is still too early for appraisal of the ultimate results of this program. I am convinced, however, that the program is sound, and I am persuaded that it will bring into existence a body of trained workers who will be imbued with the inexorable determination to push back the frontiers of the unknown which now limit so much of what we know about the diseases under study. This research program gives us what we never had before: a corps of especially gifted investigators who will devote a large portion of their lives to the study of specific problems without any cause for interruption of their labors or deviation from their objectives. It is reasonable to suppose that in the course of their work these research scientists will train others, so that we may expect a cycle that will never come to dead center. Every accession of knowledge gained thereby is a form of compensation for the great generosity of those who have supplied the funds which we expend. The dissemination of what is learned, the impetus to new research, the application of the results of investigation and the constant increase in the ranks of skilled and dedicated investigators surely are rewards which should point inevitably toward the ultimate conquest of disease.

THE PROBLEM OF DISEASE

I have spoken somewhat about the philosophy of the American Heart Association, the organization of its research projects, what I think the effects of its research program can be, and something of the financial aspects of the work of the program under way by the central organization. We ought now to give some attention to the diseases which currently are the major concern of the association. In the main, they are three, and the three of them cause at least 90 per cent of the deaths which can be attributed to diseases of the heart and blood vessels. These are rheumatic heart disease, high blood pressure and hardening of the arteries. This trinity of stubborn diseases again points up the need for continuing aggressive research, for although we can define these disease processes and can explain the effects they produce, we still do not know what is the essential cause of them. New and probably very basic knowledge about causes is what we lack at present, and well conceived and intelligently executed investigation is the only way to get such information.

I cannot say, and certainly no one would be foolhardy enough to claim, that for a given amount of funds we can produce cures for the several diseases against which we are striving. The scientist usually proceeds from a foundation of basic facts which are known. We do not have these basic facts, so far as causation is concerned. Hence, in research into cardiovascular disease the paramount emphasis inevitably must be placed upon the acquisition of knowledge about

Continued

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basic causes. This in turn requires the exercise of much patience and resolution. There is no reason why methods of treatment should not improve, as they certainly have improved, while we are still occupied in the search for basic causes. We cannot expect immediate answers to the multitudes of questions before us, but we ought not to fall into the grievous error of asuming that no progress is being made simply because the basic causes of these diseases continue to elude us.

Actually, we all know that some people today are living useful and relatively normal lives who 15 or 20 years ago would have died at an early age or would have subsisted as invalids. Treatment has advanced most remarkably. Dr. Paul D. White has said that more progress in the conquest of cardiovascular disease has been made in the past 20 years than in the preceding 2,000 years. We can thank the physicians and scientists in this audience and their colleagues for this splendid achievement. I am pleased this is so. Yet we have to face the fact that 800,000 Americans continue to die annually of disease of the heart and blood vessels. This is a sobering reflection when we find ourselves in an expansive frame of mind about modern progress in the attack upon these particular diseases.

Death and disability are never governed by geography. What research discovers in New York City can be put to the benefit of the people of Indiana, Maine, of Oregon, or of almost any other part of the world. All over the world there are people, and as people we are all susceptible to the assaults of the same antagonist in the form of diseases of the heart and blood vessels.

Secondarily, may I suggest that, working with your board of directors, you endeavor to devote a higher proportion of your organization's income to research. I have mentioned this point before, but I am convinced it is worth additional emphasis. It is largely through the rewards of research that all of us, as well as our children, can benefit from, as well as justify, the mighty flood of dollars which has come to us from the boundless generosity of the people of America.

THE PROGRAM OF EDUCATION

The American Heart Association carries on an active program of education. For physicians there are our official publications, *Circulation*, *Circulation Research* and *Modern Concepts of Cardiovascular Diseases*. The last goes to about 100,000 physicians and medical students, including many in your own splendid medical center here. We have an annual national scientific program which attracts the attention and the participation of the finest minds in the nation in both treatment and research. Then, there are numerous meetings sponsored by affiliates; these are well known to you in Indiana. There are numerous other programs for specialists in the field of diseases of the heart and blood vessels, for general practitioners and physicians generally. In 1956, during ten months of which I was President-elect and during two months of which I was President of the American Heart Association, my participation in medical meetings of various sorts totalled 72 days; 1957 will be even a bigger year.

The philosophy behind all this professional education is quite simple. People can receive the best possible care only if physicians are fully informed. The ultimate goal of research is not mere acquisition of knowledge, but rather, the widest possible dissemination of that knowledge and the application of it to the care of patients.

The American Heart Association carries on an active program of education for those of our citizens who are not scientists or physicians. In the year 1955-1956 more than 19 million pieces of literature were mailed from the central office of the American Heart Association; much of this vast quantity of literature was for the purpose of lay education. In addition, there have been multiple but uncounted radio and television programs. I believe it to be true that the American public has been and is being superbly educated in the matter of diseases of the heart and blood vessels. Yet we are not satisfied—an even more active program is being planned.

THE COMMUNITY SERVICE PROGRAM

I have said that the ultimate goal of research is not only the acquisition of knowledge, but also the widest possible dissemination and application of this knowledge to the care of patients. While the primary link between the laboratory and the patient is the individual physician, there are often situations in which the fullest application of knowledge requires resources greater than any individual patient or physician can provide.

Prevention of disease—for example, prevention of recurrences of rheumatic fever—is one of the

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areas in which the resources of the many must often be brought together to supplement and enhance the efforts of the individual physician, always, naturally, with his support and help. Rehabilitation—the need to provide work and a return to usefulness for those of our citizens afflicted with diseases of the heart and blood vessels—is another such area. These are two of the main fields in which we feel that the development of community services can help ensure that widest application of knowledge which is the objective of research.

In every talk which I have given, I have supported the idea of community service and education, and I have strongly advocated such an idea in private views. I have also said that research is our major effort. Now I would place these two statements in their proper focus, so far as the American Heart Association's program is concerned. Research is the wellspring; professional and public education and community service are the channels through which we help to lead the life-giving stream of knowledge to the people.

In developing community programs that meet the particular needs of their own people, the several heart associations must of course work with other health groups, both to ensure their own greater effectiveness and to avoid duplication of effort. For example, through the National Heart Institute, the United States Public Health Service is also active in the field of community service. It follows that our program of community service must be co-ordinated with that of the National Heart Institute as well as with others, lest we spend money injudiciously—money so freely given to the Indiana Heart Foundation and to the American Heart Association. Such co-ordination is being actively pursued at the national level.

In line with this concept of avoiding duplication, one of the most useful programs developed by many local heart associations has been the information and referral services through which patients with cardiovascular diseases who are seeking help can be directed to facilities or agencies already provided by the community. Often, as a result of their familiarity with existing resources, heart associations learn of some pressing need which is not being met and which no other agency in the community is in a position to meet. This may be the lack of a valuable diagnostic instrument at the local hospital or clinic, for example, or the lack of personnel with which to follow up the condition of children for whom prophylactic drugs have been prescribed for the prevention of recurrences of rheumatic fever. In such cases the full value of the physician's skill or recommendations is not being realized. Under circumstances like these, heart associations may find a way to meet the need. Naturally, they should always assess the need for the particular community service in terms of their entire program.

What I have said about community services should not blur the importance of the individual's own responsibility to act for himself as far as possible. At this point I would recall to you the inherent honesty and wisdom expressed in the credo of "Abilities, Incorporated," resolutely and even defiantly written by a group of people who ordinarily would be considered to be disabled. These are the words: "I do not choose to be a common man. It is my right to be uncommon if I can. I seek opportunity, not security. I do not wish to be a kept citizen, humbled and dulled by having the state look after me. I want to take the calculated risk, to dream and to build, to fail and to succeed. I refuse to barter incentive for a dole. I prefer the challenges of life to the guaranteed existence, the thrill of fullfillment to the stale calm of Utopia. I will not trade freedom for beneficence, nor dignity for a handout. I will never cower before any master nor bend to any threat. It is my heritage to stand erect, proud and unafraid, to think and act for myself, enjoy the benefit of my creation, and to face the world boldly and say, 'This, I have done.' "

I should like now to consider some entirely new problems currently before the American Heart Association. I hope that you in Indiana can be pioneers in some of these activities.

1. *The Student American Heart Association.* I may say at the beginning what many of us already know: that we have a deficit of trained scientific minds and, to a lesser degree, of physicians interested in diseases of the heart and blood vessels. With this deficit in mind, the American Heart Association is establishing a Student American Heart Association. How will it work in Indiana? As one means of creating maximal interest in the idea, I suggest that you develop in the Indiana University School of Medicine a thesis contest, in which the author of the best

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essay as selected by the faculty of the school would receive a modest financial reward. This would mean that adequate publicity could be arranged for the presentation of an appropriate citation and a special medal to the winner of the award. Moreover, the expenses of the winner of the award for travel to the annual Scientific Assembly of the national association would be paid by the Indiana Heart Foundation. In addition, some physician or scientist would be appointed to guide the winner about the assembly, so that he would not be lost amid the hectic activities of the annual session. He would be privileged to attend the scientific sessions, the meetings of the assembly and the deliberations of the various panels. The message he would take back to his fellow medical students could not have other than a lasting and favorable impression on them. Of course, we want all medical students to be members of the Student American Heart Association; the thesis winners will be delegates to the annual session.

2. *Encouraging the Interest of High School Students.* In common with other national voluntary health agencies, the American Heart Association is attempting to interest high school students in careers in medicine and biologic research. One of the media to be used is television, and the programs will be provided at a time when there is the greatest viewing audience of high school students. This is obviously an expensive program which cannot be supported by Heart Funds while we continue to carry on and extend our present program. Hence, for this special activity we need a sponsor or sponsors. I have carried out correspondence with a number of presidents of corporations about this matter. In addition, the subject has been discussed at the meeting of the National Radio and Television Committee which was attended by many representatives of the radio and television networks and advertising agencies. I have an appointment with Mr. Edward Stanley, director of the public service programs of the National Broadcasting Company, on February 21.

I am sure that many of you in the audience will have some ideas in this respect which will help us, and I hope you will transmit them to me. You may not know that we have to compete with industry, which carries on an extensive and active program of recruitment in secondary schools, colleges and universities. Even the Federal Bureau of Investigation has an active program of recruitment of young graduates. It is obvious, I believe, that the attraction of good minds into such fields of endeavor can result only in a steady decrease in the numbers of capable young people who will be interested in careers in the biologic sciences. We must work actively to maintain and improve our own position. The matter is being considered actively on a national level by the Committee to Review Research Policy. At the last annual meeting of the assembly of the American Heart Association, the panels on "Five-Year Planning" and on "Research" recommended that the American Heart Association and its affiliates consider the recruitment of research manpower at the high school and college levels, and support such recruitment efforts as may yield results. It was further recommended that support of teaching of the subjects of diseases of the heart and blood vessels in medical schools be considered on a limited and personal basis. These recommendations have been approved by the Board of Directors of the American Heart Association. Dr. Irvine H. Page, past president of the American Heart Association, has recommended that active attempts be made to improve the quality of teaching of the biologic sciences in the secondary schools.

I have another suggestion for you. The Indiana Heart Foundation should send into our high schools capable speakers whose specific purpose would be to attract the interest of high school students to careers in medicine and the biologic sciences. I have found that high school students are discerning, and that they are not much impressed by "big names." Speakers should be selected on the basis of their ability to present their material in an impressive and interesting manner, rather than upon their position in the community.

Recently, General Mark Clark, Dr. Page and I had a conference with the President of the United States about some of the matters which I have presented here. I believe that substantial and tangible results will come from that conference.

I continue to be amazed that so many Americans contribute so much and so wholeheartedly to the American Heart Association. I often ask myself, "Why?" Very likely no simple reply would be forthcoming. Among the reasons must

surely be considerations of the very highest altruism, such as the sense of quiet fulfilment which arises from the selfless devotion of the generous to those who are unfortunate, disabled and infirm.

Immanuel Kant, in a famous pronouncement which has since attracted the speculations of philosophers and moralists everywhere, said that every man should conduct himself according to maxims which he would be willing to have translated into universal law. For our own purposes, this could mean that in meeting and transcending the natural frailties of the human will and spirit, we could depart at last from life secure in the conviction that we left it better than we found it.

Such a conviction surely must be among the foremost of the reasons why so many thousands of our citizens incessantly and unsparingly give their devotion and support to the American Heart Association. The mass of men who are about to leave this existence probably do not have much regard for what happens to it after they left it, but there still remain multitudes who do. The works they have done were carried out without the spur of ambition or the thought of recompense, and it is in such a spirit and in such a concept that I wish to remember the great numbers of resolute citizens who have provided us with the means of whatever advances we have been able to make against the stubborn and formidable adversaries of man's health and well-being.

As president of the American Heart Association I am imbued with a sense of profound humility, for whatever I am able to do and whatever success I may attain will depend preponderantly upon the help and the labors of others. Great enterprises are never instituted, brought to consummation and perpetuated by the efforts of one man, and the vast objectives of the American Heart Association never could be realized without the collective generosity, determined resolution and untiring labors of thousands throughout the nation who are accorded no especial distinction and seek none.

In closing, I should like very much to leave with you a fine old truism of which I do not know the author: "For never hath any man attained to such perfection but that time or use hath brought addition to his knowledge, or made correction, or admonished him that he was ignorant of much that he thought he knew."

The homely wisdom of that sentence should do much to confer the priceless gift of humility upon any man, whatever his stature in the affairs of men.

For all of us, whatever the station we hold, there are the vibrant words of one who herself knew hopeless infirmity and physical misery for most of her life, Elizabeth Barrett Browning: "The sick man thou hast served will make thee strong: the poor man thou hast served will make thee rich." Finally, let me leave this thought with you. Our task has just begun. Our path lies over a hundred hills into the future. With your help and your co-operation, that can be a bright future.

Announcing a unique new rauwolfia derivative . . .

First report on one of the most encouraging advances in psychopharmacology since the introduction of rauwolfia: a tranquilizing-antihypertensive agent which combines the potency of the rauwolfias with significantly fewer and milder side effects.

In mid-1955, Abbott Laboratories released for clinical trial a new alkaloid of *Rauwolfia canescens*. This new alkaloid, later named Harmonyl, received special attention because of the high potency and low toxicity it exhibited in extensive pharmacological testing.

Since that time, Harmonyl has been tried in conditions ranging from mild anxiety to major mental illnesses and in hypertension. Every characteristic of the drug was studied . . . evaluated . . . compared. And from the reports, one fact stands out:

- In more than two years of clinical evaluation, Harmonyl has exhibited significantly fewer and milder side effects in comparative studies with reserpine. This, while demonstrating effectiveness comparable to the most potent forms of rauwolfia.
- Most significant: Harmonyl causes less mental and physical depression. *And there are very few reports of the lethargy seen with many other rauwolfia preparations.*

This is not to suggest, of course, that side effects will not occur with Harmonyl—as with any potent therapeutic agent. But the mildness of side effects, in the few instances in which they have been reported, suggests Harmonyl as a drug of choice in conditions ranging from mild anxiety to major mental illness and in essential hypertension.

Why fewer and less severe side effects?

Some investigators suggest that the evidence of less parasympathetic effect with Harmonyl in animals might also be true in man. In chronic toxicity studies with Harmonyl this was manifested by less diarrhea, "bloody tears" and ptosis in rats than was observed with the same dosage of reserpine. Dogs also exhibited milder side effects—in particular, diarrhea. No organ toxicity or hematological change was observed with Harmonyl over a wide dosage range.

Harmonyl as a tranquilizer

While Harmonyl's safety is most impressive, clinical investigators reported other notable characteristics for this wide-range

Harmonyl*

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tranquilizer. For instance, following an eight-month study of chronic, hospitalized mental patients, Ferguson[1] reported:

- Harmonyl benefited at least 15% more overactive patients than oral reserpine.
- Harmonyl was more potent in controlling aggression, requiring only one-half to two-thirds the dosage of reserpine.
- A number of patients experiencing side reactions on reserpine were completely relieved when changed to Harmonyl.

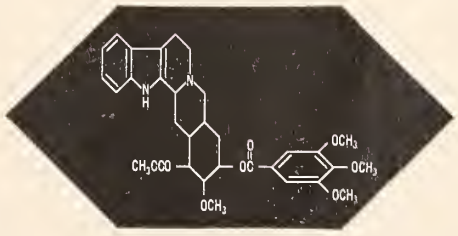
In his summary Ferguson concluded: "*The most notable impressions were the absence of side effects and relatively rapid onset of action with Harmonyl.*"

Harmonyl in hypertension

Hypertension studies show that the average reduction in blood pressure obtained with Harmonyl compares closely to that obtained with reserpine. The tranquilizing effect of the two drugs also appeared similar, except that few cases of giddiness, vertigo, sense of detached existence or disturbed sleep were observed with patients receiving Harmonyl.

Dosages In mild anxiety, as little as 0.1 mg. of Harmonyl a day may be effective. In institutionalized psychiatric patients, not less than 2 to 3 mg. a day is likely to be beneficial.

In mild essential hypertension, treatment may be started with one 0.25-mg. tablet three or four times a day. After about ten days (or sooner, depending upon response), dosage may be reduced. A maintenance dose of 0.25 mg. daily is often sufficient.



Precautions, As with other forms of rauwolfia, Harmonyl must be used cautiously in peptic ulcer and epilepsy and in patients about to undergo surgery or electroshock treatment. Despite infrequent reports involving depression, patients with a history of depressive episodes should be watched carefully.

Professional literature is available upon request.

Supplied: Harmonyl is supplied in 0.1-mg., 0.25-mg. and 1-mg. tablets.

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Reference: 1: Ferguson, J. T.: Comparison of Reserpine and Harmonyl in Psychiatric Patients: A Preliminary Report, Journal Lancet, 76:389, December, 1956.

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Some Aspects of Health and Medical Problems in the German Federal Republic

CLEON A. NAFE, M.D.

Indianapolis

THIS REPORT is based on a recent study of many problems in Western Germany which are related to the medical care and health of the German people. Six physicians and one nurse comprised the group which spent one month as guests of the Western German Government and had the opportunity for intimate conversations and discussions with leaders of the Federal Government in Bonn, officers of the German Medical Association in Cologne and with prominent medical, health, government and medical educators in various Lander (states) and municipalities throughout Western Germany. Dr. Gerald Dorman of New York City and I, as delegates of the A.M.A., represented that organization officially while others represented Public Health, Red Cross and other special groups. Our time was almost completely occupied by well-planned conferences. Yet we were also able to visit university medical schools, hospitals and other institutions of our choice and obtain an excellent over-all picture of health problems as they now exist. Any generalization concerning problems so extensive in their scope may not exactly apply in all Lander of the Republic, but I believe the summary is a fairly accurate picture of existing conditions.

THE ECONOMIC, SOCIAL AND POLITICAL SITUATION FOLLOWING WORLD WAR II

One cannot comprehend fully the present health problems in Germany without some understanding of the social and economic upheaval that followed the defeat of Germany in World War II. During our stay in Bonn, we were in conference with various leaders of the German Government and with members of the U. S. Embassy there, for the purpose of orienting us concerning the responsibilities that they have faced in bringing some sort of order out of the chaos and destruction that had resulted from a war which was the most destructive to any country in modern history.

We were reminded that within the space of 25 years, Germany had lost two wars and in them 8½ million men, and in the same time twice had seen their money and securities completely devaluated. In 1945, after the second World War, the state apparatus had been destroyed and all German territory had been occupied by the troops of four foreign governments. At the Potsdam conference Eastern Germany and East Prussia had been given to Poland and Russia. In addition Russia, a very unfriendly government, had occupied another one-third of Germany including one-third of Berlin, their largest city and their former capital, leaving it isolated from Western Germany by a distance of 100 miles to which access is limited to three air corridors 20 miles wide, the Autobahn and a waterway of which Russia has controlled the last two in a very unsatisfactory manner. As a result, the German Republic became approximately one-half the size of the former Germany with 35,000,000 people.

Following this division, 18,000,000 former German subjects, and those of German ancestry in countries adjacent to Eastern Germany (given away at the Potsdam conference) were expelled from these territories. Of this number 4,600,000 died or disappeared. Among them were 1,400,000 ethnic Germans who had been settled in Russia since the 18th century. According to recent reports, many of these are compulsory exiles in Siberia. 12,000,000 succeeded in reaching the four occupied zones of Germany, coming with very few of their personal possessions and

of these 8,000,000 reached what is now the Western German Republic. In addition, 2,700,000 refugees have migrated to Western Germany from the Russian Zone, making approximately 12,000,000 people who have migrated into Western Germany. All of these have come with very few personal belongings, without funds and often in a poor state of health. The refugees are still coming at the rate of 300 a day through Berlin and being received at the Marienfelde Refugee Center which has a capacity of 3,000 beds. From this, they are sent in 10 days to one of the 34 centers where they are kept for varying periods of time until they can be located. We visited the largest of these centers which has a capacity of 5,000 beds, has had 7,000 inhabitants, but now has only 2,000 awaiting acknowledgment—a term used to designate that a place has been found for them to be received.

These people have been received into a country that lost one-fourth of its housing, where transportation facilities, factories, and utilities lay in ruin, communications had been cut, bridges had been blown up and the whole merchant marine had been lost by the recent war.

One could not help but be impressed by the remarkable recovery that West Germany had made in spite of these problems of reconstruction. The tremendous number of new buildings that have been built are everywhere in evidence. The rubble largely has been removed and destroyed buildings have in a large measure been replaced, but there are still areas where large buildings lay in ruins. This is more especially true in a small portion of West Berlin, although as compared to East Berlin (Russian sector) there is hardly any comparison. In East Berlin, the former Reichstag building (seat of German government) and many of the surrounding buildings still lay in ruin. There are few cars on the streets, and there is very little activity as compared to West Berlin.

We were told that of 5,500,000 of the expellees and refugees that are employable, 5,400,000 have found employment in West Germany, although housing, hospital beds and like facilities are still in short supply.

We found in West Germany a stable economy; there was no rationing even of gasoline, even though this is rationed in England and France. Food was plentiful, although its cost remains relatively high since much of it has to be imported. While the mark is worth 25c (approximately) of the U. S. dollar, it probably purchases 40c worth of commodities as compared to the purchase price here.

We were reminded that West Germany had stood as a bulwark against the spread of communism, and if it had not done so that all of Europe would probably have gone communistic. German officials were quite proud of the recovery which they have made, but they stated that they never could have accomplished this without the aid of the American people for which they are extremely grateful. However, they wished us to recognize that they had received only one-third as much as England and one-half as much as France per capita in the form of monetary aid. In many places plaques on buildings stated that this building was constructed through aid given by the American people. They did not hide this fact.

PUBLIC HEALTH DEPARTMENTS AND ACTIVITIES

In the Federal Government and most of its Lander, municipalities and districts, the Public Health Department is under the direction of a physician who is responsible to the Minister of the Interior. There are 479 health offices in Germany employing 1,555 physicians full-time, and 2,917 physicians part-time. Inspectors and nurses are employed in a relatively adequate number, while sanitary engineers as such are not employed.

Following World War II and the influx of many expellees and refugees, with housing and hospital facilities lacking, there was a considerable increase in infectious diseases, particularly gastro-intestinal disorders. However, following this there has been a steady decline in these diseases, so that now the rate of infectious diseases has reached the pre-war level, and compares fairly well with that of our country with some exceptions. Polio is more rare in Germany and is more severe before 1½ years of age. A very limited amount of Salk vaccine has been available for use, and just now the health departments are making an effort to secure the vaccine and put on a mass vaccination program. Vaccination for smallpox is compulsory, but the law is only 50% effective in getting this accomplished. Since social insurance pays only for the care of the sick patient, preventive medicine is

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practiced very little by the private physician. As a result, the public health departments provide preventive medical measures. Ninety-nine percent of the vaccinations are done by the Public Health Departments. Likewise, public health agencies provide periodic examinations of school children, compulsory chest x-rays each three years, mental health advice, marriage counseling and prenatal advice. Very little prenatal care is provided, although in some areas an effort is being made to develop prenatal clinics.

Sanitation presents one serious problem. As of now, many large factories dump their waste into the large rivers, making them unfit for water supplies without much purification. Very few fish can live in these streams. When efforts have been made to remedy this by legislation, the manufacturers have been too powerful as a political influence for it to be accomplished.

The health departments seem to be quite stable and expressed the view that very few of the personnel are affected by governmental changes except a few top officials. We had the impression that the health departments were doing a very good job with somewhat limited personnel.

MEDICAL EDUCATION IN GERMANY

Medical education in Western Germany varies considerably from that in the United States. There are 17 medical schools conducted by the Lander and/or municipalities. Graduates are licensed by the Lander, but the physician is permitted to practice anywhere in the German Republic. There is a constitutional provision that anyone successfully graduating from the gymnasium has the right to enter any university. There are no admission committees to medical schools, although from time to time the medical profession and medical educators have tried unsuccessfully to set up more exacting standards for admission to medical schools.

The preliminary education, however, is different than here. Their educational system comprises 4 years of grade school and then 9 years of gymnasium, so that the student has had 13 years and is usually 19 years of age when he graduates from gymnasium instead of the age of 17 or 18 when pupils graduate from high school here. Furthermore, their educators contend that their gymnasium is much more difficult and furnishes educational courses ordinarily found in our first year of college.

When the student enters medical school, he is required to study 5½ years of 7 months each. This 7 months consists of 4 months in school, 2 months vacation, 3 months in school and 3 months vacation. He is required to study 2½ years of preclinical courses and then 3 years of clinical medicine. The preclinical studies include embryology, physics, physiology, chemistry and anatomy, many of which studies are included in our premedical courses. Following these, the students must pass a rather severe test before entering their clinical courses. This is about the last opportunity to eliminate unsatisfactory students. If students fail, they can repeat their courses, one professor stated 3 times, while another stated as long as their finances hold out. During their clinical years, their education is supplied by the professors lecturing to them on various subjects in large amphitheaters of the hospital. They have no clerkships or contact with patients unless they serve as hospital attendants during their vacation periods.

They may attend any school they wish, and frequently receive their lecture courses in several different universities. They consider this an advantage because it gives them an opportunity to learn from the outstanding professors of different schools. No attendance record in class is taken. The one requirement is that they must study the last two semesters in the school from which they expect to get a degree.

There are no single medical school buildings as we have here, but their classes are at first scattered in the various university buildings and in the clinical years in the hospitals. A Dean of the medical school is elected each year by the professors, and is usually glad to be relieved of the responsibility at the end of one year. We got the impression that the medical school was not a well-knit organization.

One professor stated that 15% of his students are outstanding, 65% average, and 20% poor, and that he would be very happy if he could only get rid of that 20% of indifferent, careless stargazers.

Following completion of the clinical years, the student is given a prolonged oral examination lasting two weeks or more upon all of the subjects. If he passes, he is certified as a physi-

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This is the most pressing objective of the United States, England, France and the Bonn Government as recently stated in newspaper comments. Whether that can be successfully accomplished in the near future depends very much on the attitude of Russia. When this is accomplished, there should be more opportunity to improve the economic and health problems in Germany.

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Professional Liability Subject of Second Film in New AMA Series

The second film in the new American Medical Association-American Bar Association series on "Medicine and the Law" will deal with prevention of professional liability action, it has been announced by Dr. George M. Lull, secretary and general manager of AMA. "The Doctor Defendant" will be available from the AMA Film Library for medical society or association showings beginning July 1.

The new film dramatically presents four case reports of situations which caused legal action against physicians. The 30-minute black and white film also demonstrates how a professional liability committee functions. It will be premiered at the June convention of AMA in New York.

"The Doctor Defendant" is a companion film to "The Medical Witness" in the series being produced by the Wm. S. Merrell Company, Cincinnati, pharmaceutical laboratories, in cooperation with the AMA and ABA as a service to the medical and legal professions.

Medical societies are urged to arrange advance bookings of the film for 1957 and 1958. For details and dates write to Film Library, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois, or to Dr. John B. Chewning, The Wm. S. Merrell Company, Cincinnati 15, Ohio.

Two glamor girls boarded a crowded street car, and one of them whispered to the other: "Watch me embarass a seat from one of the men!"

Pushing her way through the standees, she bore down on a gentleman who looked substantial and embarrassable.

"My dear Mr. Brown," she gushed, "Fancy meeting you on the car. Am I glad to see you—you're getting to be almost a stranger. Oh, am I tired!"

The sedate gent looked up at the girl he'd never seen before and as he arose, he said for all to hear, "Sit down, Bertha, my girl. We don't often see you out on wash day. No wonder you're tired. By the way, don't deliver the washing till Wednesday. My wife's going to the district attorney's office to see if she can get your husband out of jail!"

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Britain's Health Service of No Value to Anthony Eden Who Seeks Treatment in U.S.

WHILE BRITAIN'S National Health Service is in the throes of a crisis, Anthony Eden made a hurried 11,000-mile trip from New Zealand to the Lahey Clinic in Boston for emergency medical care.

Apparently the former British prime minister wanted no part of his country's medicine, which was socialized a decade ago.

It's the second time he has sought medical attention at the Lahey Clinic. He underwent surgery there in 1953 to correct a bile duct obstruction. Mr. Eden is now suffering from a liver ailment.

Just a few weeks before his arrival here, Britain's 40,000 socialized medicine doctors threatened to strike unless the government quits stalling on their demand for a 24 per cent increase in pay. The matter now rests with a royal commission which is to make a study report in October.

"Why did the once prominent ex-prime minister choose an American hospital instead of one in his homeland?" Mrs. Stephen C. Bacheller asked in one of her recent letters to me. She is area legislative chairman of the Woman's Auxiliary to the A.M.A. in Enderlin, N. D.

EDEN NOT THE FIRST

"Of course," she then added, "Mr. Eden isn't the first foreign notable to take advantage of the excellent medical care available in the United States."

The truth of the matter is that British doctors have been on a demoralizing treadmill for a long time, with the result that they have been progressively losing their freedom and status as a learned profession.

Good medicine simply can't flourish in such a climate. Possibly Mr. Eden is well aware of this; hence his hurried air trip to the Lahey Clinic.

George F. Lull, M.D., in AMA Secretary's Letter

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Deaths . . .

Edward A. Brown, M.D., retired Indianapolis physician, died March 15 in St. Vincent's Hospital. He was 84.

Dr. Brown practiced at Fountain Square in Indianapolis for 57 years. He retired two years ago from the general practice of medicine.

Born in New Bethel, Dr. Brown had lived in Indianapolis for 60 years. He was a graduate of Butler University and received his degree in medicine from the Medical College of Indiana at Indianapolis in 1898. He was one of the first interns to serve at St. Vincent's Hospital. In 1904 he received a fellowship in surgery at Bellevue Hospital, New York. Dr. Brown served with the Medical Corps during World War I and received additional postgraduate work in surgery at Rockefeller Institute. He was on the Department of Surgery faculty at Indiana University School of Medicine from 1911 until 1949.

Dr. Brown was the son of Dr. Samuel Brown, who had also been in practice 57 years at the time of his death.

Dr. Brown was a member of Indianapolis Medical Society, a Fifty Year Club and senior member of the Indiana State Medical Association, and a member of American Medical Association. He formerly served as vice-chairman of the Section on Surgery of the Indiana State Medical Association.

Dr. David E. Brown, Indianapolis, is a son.

Charles W. Yarrington, M.D., Gary physician, who had the distinction of being the first fulltime school physician in the United States, died from a coronary thrombosis March 25 while fishing near his winter home at Clearwater, Florida. He was 80 years old and still in practice, although for the last seven years he had spent his winters in Florida.

Dr. Yarrington had many interests in addition to his profession. He had planned to return to Gary on April 12 to be honored that night by the Gary Red Cross chapter for his 40 years service to that organization. He was a charter member and had been on the board for 40 years.

Dr. Yarrington was a Fifty Year Club and senior member of the Indiana State Medical Association, had been a member of the University of Michigan's Emeritus Club since 1952 when that school honored him for his 50 years in medicine; was a 50 year member of the Masonic Lodge and a member of other Masonic orders; was a charter member of the Gary Rotary Club; a vestryman in his church for many years; he was a member and president of the Gary Commercial Club, and a charter member of Gary Country Club.

For 10 years before going to Gary in 1912, Dr. Yarrington had been company physician for the Calumet and Hecla Mining Company on Lake Superior in upper Michigan. He served as fulltime school health officer for two years after establishing his residence in Gary and entered general practice in 1913. He served briefly during World War I as a captain.

Dr. Yarrington helped promote Gary's first hospital, was on the first executive committee of Mercy Hospital and later served as president of the staffs of both Mercy and Methodist Hospitals. He was president of Lake County Medical Society in 1934, had served on the Committee on Industrial Health of ISMA. Dr. Yarrington was a member of the American College of Surgeons. In addition to his county and state memberships, he also was a member of the American Medical Association.

Arthur H. Hansen, M.D., 60, died of a heart attack while attending a meeting of the Hammond Board of Zoning Appeals on March 26. He was an ophthalmologist.

Dr. Hansen received his degree in medicine from Rush Medical College in Chicago in 1924.

He had been a member of Lake County Medical Society and the St. Margaret's Hospital staff

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for 30 years. Dr. Hansen also held church and lodge memberships.

Robert Jordan Millis, M.D., 59, died April 8 in his Crawfordsville home. He had been ill since March 1948 and in retirement since 1950.

Dr. Millis was born in Attica. His father was later superintendent of Crawfordsville schools and president of Hanover College. Dr. Millis was graduated from Hanover and received his degree in medicine from Indiana University School of Medicine in 1920. He established his practice in Crawfordsville in 1921.

During his years in that city he served as Crawfordsville city health officer and in the same capacity for Montgomery county for several terms. He was also a member of the school board for a number of years.

Dr. Millis served as a captain in the Army Medical Corps from September 1942 until August 1945, when he received a medical discharge after suffering a major disability.

Dr. Millis held church, fraternal, patriotic, lodge and service organization memberships. He was a member of Montgomery County Medical Society, the Indiana State and American Medical Associations.

Charles F. Kaadt, M.D., 84, former Fort Wayne and South Whitley physician, died March 29 in a Columbia City nursing home where he had been a patient for five weeks.

A native of Denmark, he came to the United States when a small child. Dr. Kaadt was in practice in Fort Wayne and served as district surgeon for the Wabash and Grand Rapids and Indiana railroads for 30 years before going to South Whitley.

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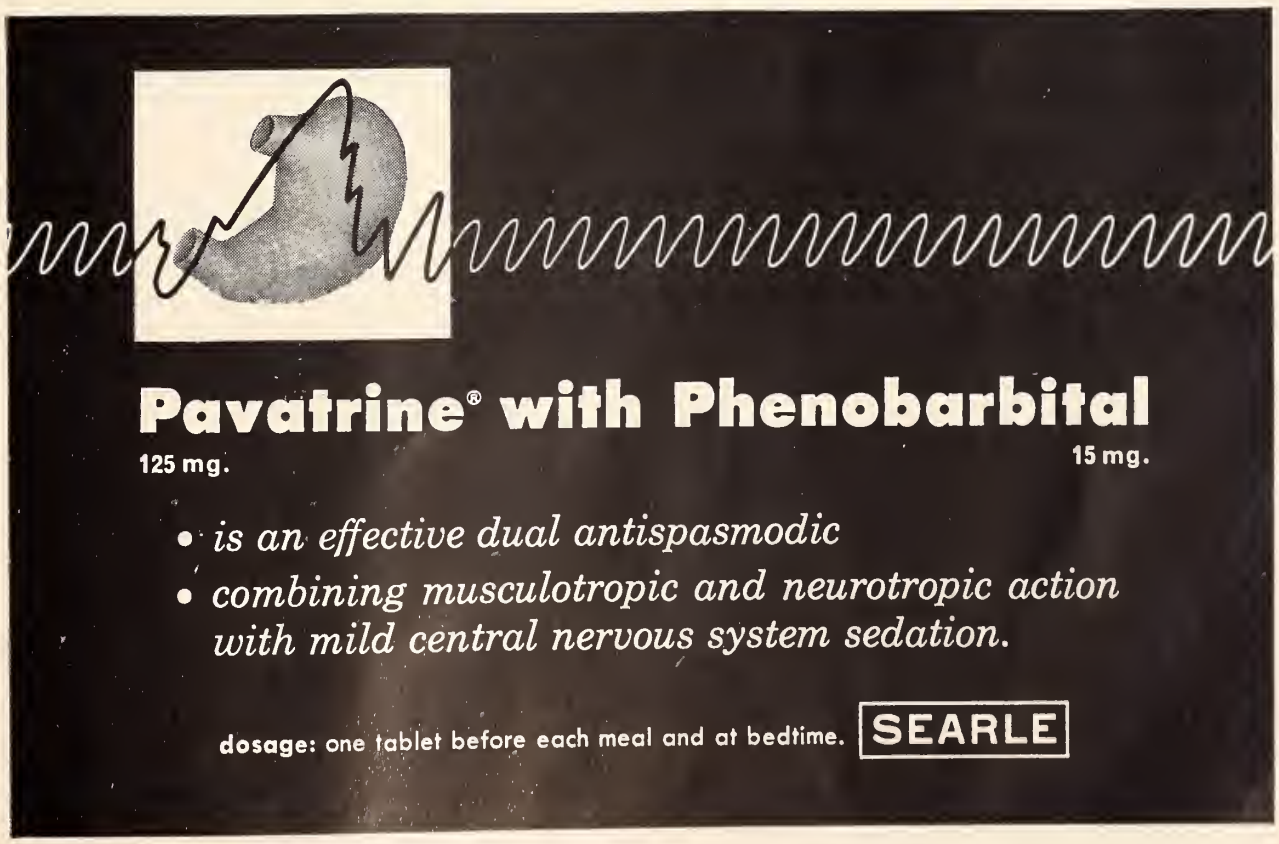

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NEWS NOTES—from State and Nation

Norways to Remain Open Until September 1, Officials Report

Norway Foundation Hospital, which earlier had announced the possibility of a June 1 closing, now plans to remain open at least until September 1, hospital officials stated this month.

The Nursing School at St. Joseph's Hospital in Fort Wayne, one of the hospitals participating in the Norways Psychiatric Nurses' Training program, has indicated plans to send another class for psychiatric affiliation for the summer term, so it is expected that the nurses' training program will also continue until fall.

The possibility of relocating the Norways Hospital in some outstate community is being considered, but any investigations so far are merely exploratory.

"The feasibility of another location for Norways will have to be studied very carefully before any decision can be made," explained a member of the Norways Board of Trustees. "Newspaper stories giving the impression that such a decision has already been made were premature. We hope the Norways Foundation can continue to serve the cause of mental health one way or another, and several possible areas of service are receiving consideration."

Dr. Josephine Van Fleet Directs State Laboratories

Announcement has been made by Dr. A. C. Offutt, state health commissioner, of the appointment effective January 1 of Dr. Josephine Van Fleet as Director of the Bureau of Laboratories, Indiana State Board of Health.

Dr. Van Fleet is a native of New Jersey. She is a 1943 graduate of Indiana University School of Medicine and served her internship and residency in pathology at the I. U. Medical Center. Dr. Van Fleet served as an instructor in pathology at the university from 1944 to 1950, and as instructor in clinical pathology there from 1951 to 1952 when she became chief of the laboratory service at the Cold Springs Road VA Hospital, Indianapolis. In 1955 Dr. Van Fleet joined the Indiana State Board of Health staff. She succeeds Samuel R. Damon, Ph.D. as director.

Dr. Van Fleet who lives at 5301 Woodside Drive, Indianapolis, is a member of local, state and national medical associations, a diplomate of the American Society of Clinical Pathologists, a fellow of the American College of Pathologists, and a member of other specialty organizations.

Dr. W. Donald Close Assumes University Post

Dr. W. Donald Close, Indianapolis internist, recently accepted a full-time position as Director of Postgraduate Medical Education at the Indiana University School of Medicine. He is also an associate professor of medicine.

Dr. Close has closed his office in the Hume Mansur Building and will devote full time to his Medical Center positions. He is a graduate of Indiana University School of Medicine.

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Dr. L. W. Spolyar Named Director of Preventive Medicine

Dr. Louis W. Spolyar, Indianapolis, has been appointed Director of Preventive Medicine of the Indiana State Board of Health, according to a recent announcement by Dr. A. C. Offutt, state health commissioner.

A graduate of Indiana University School of Medicine, Dr. Spolyar has long been associated with industrial medical problems in Indiana. His new duties simply increase the scope of his activities.

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A new 16 mm. color motion picture on the uses of steroids in the treatment of rheumatoid arthritis has been released for showing to professional groups by the research division of the Schering Corporation. The film reviews the chemistry, physiology and clinical application of the new steroid hormones in rheumatoid arthritis and other collagen diseases. The film runs 25 minutes. It is available on loan without charge from The Audio-Visual Department, Schering Corporation, Bloomfield, New Jersey.

"Complete Maternal Care" to Be Topic of Congress in Chicago

A comprehensive review of Complete Maternity Care will be presented by The American Committee on Maternal Welfare at the Seventh American Congress on Maternal Care (formerly known as the **American Congress on Obstetrics and Gynecology**) to be held at the Palmer House, Chicago, July 8-12, 1957.

The five-day Congress—under the leadership of Dr. F. Bayard Carter, professor and head of the Department of Obstetrics and Gynecology at Duke University, Durham, North Carolina, and Dr. Samuel B. Kirkwood, Commissioner of Public Health for the Commonwealth of Massachusetts and professor of Maternal Health at Harvard Medical School—will present topics dealing with the interprofessional approach to maternal and infant care. The program committee, composed of organizational representatives from obstetrics-gynecology, general practice, pediatrics, anesthesiology, nurse anesthesia, nursing, nutrition, public health, hospital administration, mental hygiene, and social service, has developed a program to afford maximum opportunity for audience participation.

Further information can be attained by writing: The American Committee on Maternal Welfare, 116 South Michigan Avenue, Chicago 3, Illinois.

A postgraduate symposium on the Basic Sciences Related to Anesthesiology will be presented June 10-14 in the School of Health Professions Building, University of Pittsburgh. The course will be limited to 50 participants. The University of Pittsburgh School of Medicine

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(Department of Surgery and Section on Anesthesiology) is sponsoring the course. Registration fee is $25.00. Full particulars may be obtained from the Chairman of the Committee on Graduate Medical Education, University of Pittsburgh School of Medicine, 3941 O'Hara Street, Pittsburgh 13, Pennsylvania.

American Medical Golfing Association Tourney to Be Held at Rye, N. Y.

The American Medical Golfing Association will hold its Forty-First Tournament June 3, 1957 at the well known Westchester Country Club, Rye, New York. It is a championship layout, with beautifully cared for greens and fairways. This famous resort provides two 18 hole courses, a Beach Club on Long Island Sound, tennis courts and even a polo field.

The Westchester Country Club located some 30 miles from Grand Central Station, can be reached easily by train or bus to Rye, or if several golfers join together by Carey Car Service or Rent-a-Car Service. Golfers wishing to have quarters closer to the Club can secure reservations at nearby hotels in Rye or Harrison, N. Y. or Greenwich, Conn.

Tournament play will start at 8:30 a.m. Players may tee-off up to 2 p.m. Buffet luncheon, banquet, prizes and green fees are included in the cost of the day's activities. The banquet will be served promptly at 7 p.m. followed by awarding of prizes. All male members of the American Medical Association are eligible to participate in the tournament. Notice of further details and advance registration card may be secured by writing Bob Elwell, 3101 Collingwood Blvd., Toledo 10, Ohio.

Players should present verification of their home club handicap, signed by their club secretary otherwise handicap is set by the A.M.G.A. Handicap Committee.

The Department of Otolaryngology, University of Illinois College of Medicine, announces its **Annual Assembly in Otolaryngology** from September 30 through October 6, 1957. The Assembly will consist of an intensive series of lectures and panels concerning advancements in otolaryngology, and evening sessions devoted to

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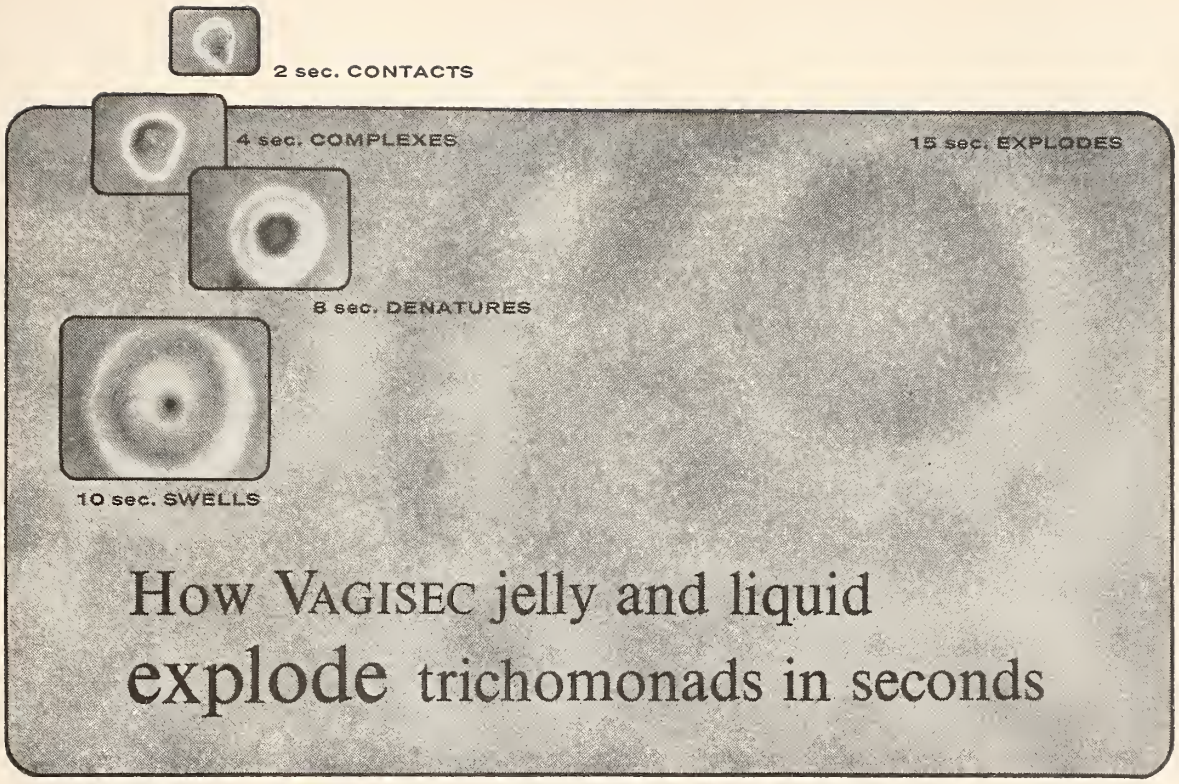

How VAGISEC jelly and liquid explode trichomonads in seconds

VAGINAL trichomoniasis quickly yields to VAGISEC® liquid and jelly.[1-5] These unique trichomonacides *explode* flagellates after 15 seconds' contact. Following a VAGISEC douche, VAGISEC jelly maintains trichomonacidal effectiveness 'round-the-clock. With this new approach, therapy succeeds in more than 90 per cent of cases.[4]

Research proves effectiveness — In hundreds of tests with slide preparations, mixtures of VAGISEC jelly and vigorous cultures of *Trichomonas vaginalis* have been examined under a phase-contrast microscope.[3,6] The trichomonads *explode and disperse within 15 seconds* after contact with jelly — exactly like those in a VAGISEC douche solution.[3-6]

Explosion succeeds — VAGISEC liquid and jelly penetrate rapidly to trichomonads covered by vaginal mucus and cellular debris and *explode* them, avoiding post-treatment flare-ups.[3-5] VAGISEC therapy often rids stubborn clinical cases of "trich" even after other agents fail.

Why parasites explode — A wetting agent, a detergent and a chelating agent, combined in balanced blend in VAGISEC liquid and jelly,[3-5] act to weaken the parasites' cell membranes, remove waxes and lipids, and denature the protein. Then the trichomonads imbibe water, swell and explode into fragments . . . all within 15 seconds.

The Davis technique† — Dr. Carl Henry Davis, co-discoverer of VAGISEC, recommends a combination of office treatments with VAGISEC liquid and 'round-the-clock home therapy with the liquid and jelly.[3] This regimen halts vaginal trichomonal infections and ensures *continuous* control until all trichomonads are gone. For a small percentage of women who have an involvement of cervical, vestibular or urethral glands, other treatment will be required.[1,3-5]

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References: 1. Decker, A., and Decker, W. H.: Practical Office Gynecology, Philadelphia, F. A. Davis Company, 1956. 2. McGoogan, L. S.: J. Michigan M. Soc. *55*:682 (June) 1956. 3. Davis, C. H. (Ed.): Gynecology and Obstetrics (revision), Hagerstown, W. F. Prior, 1955, vol. 3, chap. 7, pp. 23-33. 4. Davis, C. H.: West. J. Surg. *63*:53 (Feb.) 1955. 5. Davis, C. H.: J.A.M.A. *157*:126 (Jan. 8) 1955. 6. Molomut, N., Port Washington, N. Y.: Personal communication (Jan.) 1957. 7. Draper, J. W.: Internat. Rec. Med. *168*:563 (Sept). 1955. 8. Feo, L. G., et al.: J. Urol. *75*:711 (Apr.) 1956.

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Dr. Stewart T. Ginsberg Named Commissioner of Mental Health

Dr. Stewart T. Ginsberg, former chief of the psychiatry division in Veterans Administration central office in Washington, D. C., became Commissioner of Mental Health for the State of Indiana on May 1 by appointment of Governor Harold W. Handley. Dr. Ginsberg will also hold an appointment as professor of psychiatry at Indiana University School of Medicine, Indianapolis.

The new commissioner is a native of St. Paul, Minnesota. He is 51 years old. He received his premedical and medical degrees from the University of Minnesota, graduating in 1933.

Dr. Ginsberg has been a member of the staff of Georgetown University Medical School in Washington, is a diplomate of the American Board of Psychiatry and Neurology, and a Fellow of the American Psychiatric Association and the American Medical Association. He is a colonel in the U. S. Army Reserve.

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Dr. George J. Garceau, Indianapolis orthopedic surgeon, was scheduled to be a guest speaker at the annual meeting of the State Medical Society of Wisconsin in Milwaukee on May 9. Dr. Garceau, who is professor and chairman of the Department of Orthopedic Surgery, Indiana University School of Medicine, was to speak on "Denervation of the Plantar Muscles of the Foot" at a special program on orthopedic surgery.

Two Indiana Physicians Honored by American College of Allergists

At a recent meeting of the American College of Allergists in Chicago, Dr. Hugh A. Kuhn of Hammond was elected Vice President of the College, and Dr. Kenneth Craft of Indianapolis was named to the Board of Regents. Both Dr. Craft and Dr. Kuhn appeared on the scientific program.

Lake County Has Disaster Preparedness Meeting

More than 200 Lake County physicians and approximately 60 representatives of the Lake County Civil Defense organization and area hospitals attended a meeting during February at Mercy Hospital, Gary, to complete plans and make assignments in readiness for any community emergency.

A report was given by R. M. Jones and Dr. Paul Campbell on the handling of victims of a school bus-train wreck at Waukesha, Wisconsin, by the Waukesha Memorial Hospital.

Dr. L. J. Danielski, chairman of Mercy Hospital disaster committee, disclosed that Methodist and Mercy Hospitals, Gary, St. Catherine's in East Chicago, and St. Margaret's in Hammond are all organized to handle a disaster. Medical teams are set up for each type of injury and hospital floors have been designated for separate types of disaster patients.

Indiana Doctors Address International College Meeting

Listed among the 40 surgeons who addressed the regional meeting of the Great Lakes Division, International College of Surgeons, at the French Lick-Sheraton Hotel April 7-10, were Drs. Walter P. Moenning, professor of gynecology at Indiana University School of Medicine; Dr. Harvey W. Sigmond, assistant professor of orthopedic surgery at I. U.; Dr. Robert F. Heimburger, professor of neurosurgery; and Dr. George J. Garceau, chairman of the I. U. department of orthopedic surgery, and arrangements chairman for the meeting.

Dr. Leon E. Kresler, who formerly practiced in Rensselaer and more recently has been in practice in Winter Park, Florida, has purchased the building and equipment of Dr. Daniel F. Paul at Kentland. Dr. Paul was killed recently in an automobile accident.

Dr. Kresler planned to reopen the office late in April. He is a 1941 graduate of Indiana University School of Medicine, is married and has three children. The family will move to Kentland soon.

Six Terre Haute Physicians Build New Medicenter

Drs. Roy J. Ault, Paul J. Bronson, Robert N. Kabel, M. C. Topping, Stuart R. Combs and Robert A. Schumaker have moved to their new building at 3050 Poplar Street in Terre Haute. All previously had offices in the downtown district.

The new structure to be known as the Medicenter is a one-story Indiana limestone building with suites from 5 to 14 rooms in size. Drs. Ault and Bronson share a suite as do Drs. Kabel and Topping. Single suites are occupied by Drs. Combs and Schumaker. The building is owned jointly by the doctors who have one unoccupied suite available. Included in the plans is a building office and a business manager will handle operation of the Medicenter.

The physicians share a reception room and lounge. The building has radiant heat, year-round air conditioning and moisture control and is soundproof. Ample parking space has been provided.

Dr. Ralph W. Bruner, Jeffersonville physician, planned to resume active practice May 1 following an eight month illness and convalescence. Dr. Bruner underwent surgery last October and later contracted infectious hepatitis.

Psychiatric Association Meets at Muscatatuck State School

The Indiana Neuropsychiatric Association met on May 8, at the Muscatatuck State School at Butlerville, for a dinner and scientific program. The staff of the Louisville Child Guidance Clinic, the consultants of the school, and members of the county medical societies of adjacent counties were guests. Dr. Hans Meyer, clinical director, presented a paper on patients with Oligrophrenia Phenylpyruvica. Dr. Arthur Drew and the school staff discussed several case presentations.

I.U. Aids in Nationwide Research on Cerebral Vascular Disease

Indiana University is one of ten medical research centers which have joined a nationwide cooperative research investigation of cerebral vascular disease instituted by the U. S. Public Health Service. It is expected that from 35 to 40 institutions will eventually participate. The project is expected to run for 5 or 6 years. New light is sought on the nature and causes of strokes. More effective treatment methods will be investigated.

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News from the County Societies

Dr. Harris B. Shumacker, Jr., M.D., Indiana University Medical Center, was the guest speaker at the evening meeting of **Boone County Medical Society** on April 2 in Witham Memorial Hospital, Lebanon. He spoke on "The More Common Peripheral Vascular Lesions Which Are Amenable to Surgery." Twelve members attended the meeting.

Cass County Medical Society members made plans for a Community Health Day and discussed polio immunization and means of encouraging the public to take the series of Salk vaccine shots at a March 4 combined meeting of the physicians and the Woman's Auxiliary. Dr. Johnson Chu, a staff physician at Logansport State Hospital, was voted full membership.

On April 1 the Cass County Medical Society held a dinner meeting in the Ben-Hur restaurant, Logansport, with 30 members present. A paper on "Myocardial Infarction" was presented by Dr. Roy H. Behnke, Indiana University Medical Center.

A breakfast meeting of the **Decatur County Medical Society** was held March 20 in the Decatur County Hospital at Greensburg with 10 members attending.

The ISMA field secretary gave a complete report of the action of the Indiana General Assembly which affected the medical profession. A question and answer period followed.

L. E. Converse of Blue Shield was also a guest of the society and discussed recent developments in the health insurance field.

The society voted to give Salk vaccine shots in their offices.

The **Dearborn-Ohio County Medical Society** met March 21 in the Dearborn Country Club for dinner and a business meeting. They also viewed a film "Grand Rounds" made from a closed television broadcast on heart problems.

The ISMA field secretary reported on action of the Indiana General Assembly. The 10 members present held a general discussion on various aspects of the legislation.

At the March 19 dinner meeting of the **Delaware-Blackford County Medical Society** in the Student Center at Ball State Teachers College, Muncie, about 25 members heard a discussion of "Healthy Added Years" by Dr. E. L. Boetz. This meeting was held in conjunction with the Kirkpatrick Memorial Conference on Aging.

Twelve members and four guests of the **Gibson County Medical Society** met for dinner in the Emerson Hotel, Princeton, on April 10. The speaker for the scientific program was unable to fill the engagement and a sound and color film on "Review of Ano-Rectal Anatomy" was substituted.

Knox County Medical Society members heard a report on the Indiana General Assembly and an outline of the aims of the public relations committee of the society at a dinner meeting March 19 in the Orchard Room of the Grand

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Hotel in Vincennes. Twenty-seven members attended the meeting.

Speaking on legislation as it affects the medical profession was Robert J. Amick, ISMA field secretary, while Dr. Edward T. Edwards told of the public relations activities. Plans were also made for a three-day polio immunization program.

Dr. Max Bernstein, Chicago, was the guest speaker of the **LaPorte County Medical Society** on March 21 in the Spaulding Hotel, Michigan City. Dr. Bernstein, who is on the staff of the Edgewater Beach Hospital, associate professor of Cook County Hospital, and associate professor of clinical medicine at the University of Chicago, discussed "Factors in the Treatment of Chronic Congestion in the Aged." His presentation was reported as excellent, evoking many questions.

Thirteen members attended the meeting.

"Surgery in Infants and Children" was the topic of a paper presented by Dr. Edward J. Berman, Indianapolis, before 18 members of **Lawrence County Medical Society** on April 3. The luncheon meeting was held at noon in Dunn Memorial Hospital, Bedford.

Fifteen physicians were elected to membership in the **Indianapolis (Marion County) Medical Society** at the regular meeting March 19 in the Empire Auditorium.

Guest speaker for the evening program was Dr. John Mulholland, New York University, whose topic was "Cholecystitis." He was introduced by Dr. H. B. Shumacker, Jr.

Dr. James M. Leffel, president, welcomed the new members and announced that all members were invited to a closed circuit TV broadcast March 27 as guests of the Upjohn Company.

New members of the society are Drs. William J. Pierce, transfer from Tippecanoe County; James J. Meany, transfer from Kenosha, Wisconsin; Robert H. Addleman, transfer from Wayne-Union county; Jack C. Siebe, Joseph Roshe, Audrey H. Nelson, Snead W. Morgan, Jack H. Hall, James H. Harshman, John Gra-

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ham, James N. Easter, Paul K. Cullen, Jr., Robert J. Burkle, Franklin N. Booth and B. L. Balingit.

At the April 9 meeting of the society Dr. Robert H. Browning, director of the Ohio State Tuberculosis Hospital in Columbus, spoke on "Tuberculosis and the Practicing Physician in 1957." He was introduced by Dr. A. G. Popplewell. Special guests at the meeting were members of the board of directors of the Indianapolis Health and Hospital Corporation, and staff members of the Marion County Tuberculosis Association. Guests were introduced by Dr. James M. Leffel, president.

A resolution memorializing Dr. Samuel J. Copeland was read. Dr. Russell A. Sage was chairman of the resolutions committee. Serving with him were Drs. John R. Swan and J. William Wright.

New members elected to the society following approval by the Council were Drs. Maurice A. Turner, transfer from Gibson county; John N. Lein and Ester Hizon.

Twenty members of **Montgomery County Medical Society** held an evening meeting March 21 in Culver Union Hospital, Crawfordsville. Dr. Philip T. Holland, Bloomington, was the speaker. He gave a detailed description of an experiment in Monroe county using "Pap smears" in cancer detection, with local physicians and the Monroe County Cancer Society cooperating.

Dr. Thomas J. Conway, Terre Haute, presented a paper on "Anemia in Children" before 10 members of the **Parke-Vermillion County Medical Society** March 21. The meeting was held in the Vermillion County Hospital, Clinton, where dinner was served to the members and several guests.

A legislative report was given by R. J. Amick, ISMA field secretary.

A film on "Metabolic Insufficiency Syndrome" was shown at the **Perry County Medical Society** meeting April 2 in the Perry County Nursing Center in Cannelton. Seven members were present and also discussed plans for a mass immunization of the county residents who had qualified for free polio shots.

Steuben County Medical Society members discussed two polio clinics planned for April and May at their April 1 meeting in the Hendry Hotel, Angola. Seven members attended the 5:30 meeting and dinner.

The annual Medical-Civil dinner supplanted the regular March meeting of the **Vanderburgh County Medical Society.** Speaker at the sixth annual dinner given by members of the medical profession for fellow townsmen who are leaders in civic affairs of Evansville was Aubrey Gates, director of the American Medical Association Council on Rural Health.

A committee under the chairmanship of Dr. Robert C. Little was named at a recent meeting of the board of directors of the society to consult with high school students entering the April 6 Science Fair at Evansville College. Other committee members are Drs. W. D. Snively Jr., G. T. Hermann and Mell B. Welborn. Funds were also allocated for prizes for the students winning the contest.

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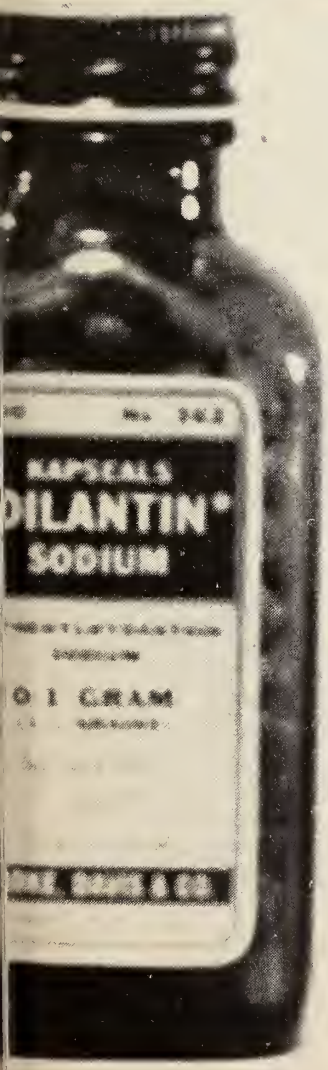

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1. Zimmerman, F. T., and Burgemeister, B.: *Arch. Neurol. & Psychiat.* 72:720, 1954.
2. Zimmerman, F. T., and Burgemeister, B.: *J.A.M.A.* 157:1194, 1955.
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June 1957

of the INDIANA STATE MEDICAL ASSOCIATION

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District	President	Secretary	Place and date of meeting
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2.	Sam I. Rotman, M.D., Jasonville	J. S. Brown, M.D., Carlisle	Linton, June 6, 1957
3.	Wm. H. Robinson, M.D., Mitchell	Joseph C. Dusard, M.D., Bedford	
4.	William A. Johnson,. M.D, North Vernon	Benet W. Thayer, M.D., North Vernon	
5.	Jack R. Glosson, M.D., Clay City	John M. Palm, M.D., Brazil	Brazil, 1958
6.	H. N. Smith, M.D., Brookville	Kenneth G. Hill, M.D., New Castle	Greenfield, May 8, 1958
7.	T. V. Petranoff, M.D., Indianapolis	Arthur W. Records, M.D., Franklin	
8.	F. W. McDowell, M.D., Muncie	Clyde G. Botkin, M.D., Muncie	Muncie, June 12, 1957
9.	J. A. Van Kirk, M.D., Frankfort	Dan Tucker Miller, M.D., Fowler	Tipton, 1958
10.	E. J. DeGrazia, M.D., Valparaiso	Wm. C. Robertson, M.D., Chesterton	Whiting, Sept. 4, 1957
11.	Earl W. Bailey, M.D., Logansport	Charles L. Wise, M.D., Camden	Marion, Sept. 18, 1957
12.	Milton F. Popp, M.D., Fort Wayne	Harold F. Zwick, M.D., Decatur	Fort Wayne, 1958
13.	R. E. Nelson, M.D., South Bend	O. E. Wilson, M.D., Elkhart	South Bend, Nov. 20, 1957

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This summary of what is happening in Washington is prepared by A.M.A.'s capital office and airmailed to THE JOURNAL on the ninth of each month.

THE MONTH IN WASHINGTON

Washington, D. C.—Again the Jenkins-Keogh plan is up for consideration in Congress. While there is no assurance it will be passed, or even get out of the House Ways and Means Committee, many sponsors of the legislation this year are united in one organization and are making themselves felt on Capitol Hill.

Briefly, this bill would allow any self-employed person to put a limited portion of his income into a retirement fund without paying income taxes on the money. Taxes would be paid when the money was received as pension or retirement.

Sponsors of the Jenkins-Keogh plan point out that it very definitely is not legislation to give a special tax advantage to one group of people. For one thing, every self-employed person would be eligible, from farmers to doctors and from opera singers to architects. For another, corporations since 1942 have been allowed to put money into retirement funds for their employees without payment of federal taxes on the money; the self-employed merely want the same consideration.

At various times the American Medical Association has led in the campaign for enactment of legislation of this type. Two years ago the House Ways and Means Committee voted to report it out, as part of a broader tax bill, but the committee never actually got around to sending the combined bill to the House floor.

Now the lead is being taken by a newly-formed American Thrift Assembly, or officially the American Thrift Assembly for Ten Million Self-Employed. In addition to the AMA, the new group has the support of American Dental Association, American Bar Association, and a score or more of other national organizations that represent the self-employed.

GRASS ROOTS ACTIVITY

After the Congressional session was well under way, the ATA surveyed the political-legislative climate and found it favorable for Jenkins-Keogh. Then in early May the Assembly asked its constituent associations to go to work. They were urged to have all members contact the House Ways and Means Committee with requests that the Jenkins-Keogh bill be reported favorably to the House floor. Assembly strategists are confident that if the committee hears from enough of the people who would be affected, it will approve the bill before adjournment. Then, if there isn't time for House action this year, that step can come next year.

Economy has been the main obstacle in the path of Jenkins-Keogh—the fear on the part of the Treasury Department that passage of the bill would mean a serious loss of income tax revenue. However, the Treasury has never denied that the bill is justified to equalize tax status for the self-employed in relation to corporation employees.

Answering the economy argument, the Assembly makes two points:

First, the set-aside funds, invested in the country's economy, would stimulate business and develop far more in new income tax payments than it would cost.

Second, because the self-employed who retain their health rarely retire at any arbitrary age,

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many of them in the years past 65 would remain in a tax bracket not significantly lower than when they paid into the retirement fund.

NOTES

When Congress votes the money, the new home of the **National Library of Medicine** will be constructed at Bethesda, Md., near the National Institutes of Health and the Navy Medical Center. This site was selected by the board of regents at its second meeting.

At the request of Speaker Rayburn, the House Interstate and Foreign Commerce Committee has set up a special subcommittee with authority **to find out if government agencies are expanding their operations beyond limits intended by Congress.** The subcommittee expects to continue its investigations between the sessions of Congress.

The continuing **national health survey** is under way. Each month from now on, 140 Census Bureau interviewers will visit 3,000 homes, asking questions about illness and disability. On the basis of the data collected, the Public Health Service will publish national and regional reports on morbidity and mortality.

Because of his achievements in the advance of mental health, **Dr. William C. Menninger** has been selected by the U. S. Chamber of Commerce as "one of the great living Americans."

Because of widespread interest aroused by Senate hearings, there is considerable pressure for action before adjournment on legislation for some form of **federal control over union welfare funds.** One bill, by Senator Goldwater, would lay down strict procedures, including regular audits.

Also before Congress, but not making rapid progress, is a bill that would give the federal government **control over amphetamines and barbiturates.** Various types of bookkeeping and registration would be required, but physicians would be exempt from the requirements. It has administration support.

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1. Herrell, W. E., Erythromycin, Antibiotics Monographs, No. 1, p. 34, New York, Medical Encyclopedia Inc., 1955. 2. Eastman, G., Cook, E. and Bunn, P., N. Y. State J. Med., 56:241, 1956. 3. Solomon, S. and Johnston, B., Amer. J. Med. Sc., 230:660, 1955.

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During the latter part of March and the month of April several inquiries were received by the Physicians' Placement Service of the Indiana State Medical Association concerning good communities in which to establish a medical practice and three additional communities sought assistance in locating a physician. They are:

LOCATIONS

PLAINFIELD—Hendricks County; population 2,600. Located 18 miles from Indianapolis on U.S. Road 40. This is a very rapidly growing community. There are four physicians in the community. For further information contact Dr. M. M. Aiken, Plainfield.

GOODLAND—Newton County; population 1,250. Located in rich farming section of Indiana. One physician in the community. Preliminary plans are underway for a county hospital located 8 miles from Goodland. Building available which was specifically built for a doctor's office. For further information contact Mr. Lawson J. Cooke, Cooke's Pharmacy, Goodland.

CLARKS HILL—Tippecanoe County; population 500. Located close to Frankfort and Lafayette, where good hospital facilities are available. Office building available. Contact Mr. Paul Marks, Postmaster, Clarks Hill.

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R. E. Hames, M.D. (general), U. S. Army Hospital, Dugway, Utah.

Robert S. Forbes, M.D. (general), 924 Clark Street, Redlands, Calif.

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Louis Byrne, M.D. (general), 1711 West Green Street, Decatur, Illinois.

A. W. Kilness, M.D. (general), Hot Springs, South Dakota.

Hugh F. DeMorest, M.D. (general), St. Mary of Nazareth Hospital, 1120 N. Leavitt Street, Chicago 22, Illinois.

Capt. Gerald Sandler (general), 2845 USAF Hospital, Griffiss AFB, Rome, New York.

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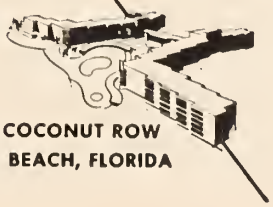

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Indiana Mental Health Plan Aimed at Reducing Return of Discharged Patients

A MENTAL HEALTH PLAN in Indiana, sparked by a Veterans Administration psychologist, is tackling one of the most critical problems of patients who are ready to leave the hospital.

The plan is for all agencies and hospitals in the state, concerned with rehabilitating the mentally handicapped, to coordinate their work so that a patient at the time of discharge will have these guidance and rehabilitation facilities at his call.

The cooperative program, aimed at reducing the return to hospitals of one out of every two released mental patients, was developed from a historic three-day meeting last year, attended by 250 Indiana officials from every agency and institution in the state that deals with the mentally ill.

The VA psychologist who suggested the institute is Durand F. Jacobs, Ph.D., chief of the vocational counseling service at the Marion VA hospital.

Dr. Jacobs presided at the meeting which decided that the principal reason for an average of more than 50 per cent of released mental patients eventually returning to the nation's mental hospitals was that there was insufficient preparation of the patient for the transition to community life.

Dr. Harry G. Hockett, manager of the Marion VA hospital, told the group how VA counseling psychologists prepare the veteran-patient for the social and vocational problems that await him in the community, as well as assist the veteran in the crucial transition to productive civil life.

He explained how VA neuropsychiatric hospitals equip patients for gainful employment through the use of member-employe program, vocational apprentice program, and day or night treatment programs which make it possible for the patient to spend part of each 24 hours in the community.

The 250 Indiana officials drew up plans to coordinate planning, particularly in matters of reports and inter-agency correspondence. They felt by working together as a state-wide team they could provide a smoother transition to the community for the patient, avoid duplication of effort, and put complete information in the hands of community agencies which take over the rehabilitation effort after the patient is released from the hospital.

As a result of the three-day meeting, the group has just completed a central reporting exchange for the use of Federal, state and local institutions and agencies, which, they said, is unique in the mental health field.

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An Irishman, after paying his respects in the cemetery, walked about looking over some of the old tombstones. He stopped before one on which was engraved: "Here lies Sandy MacGregor—A Generous Father and a Pious Man."

"Huh!" exclaimed the Irishman. "Just like the Scotch—three men in one grave!"

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References: 1. Borrus, J. C.: *M. Clin. North America,* In press, 1957. 2. Gillette, H. E.: *Internat. Rec. Med. & G. P. Clin.* 169:453, 1956. 3. Pennington, V. M.: *J.A.M.A.,* In press, 1957. 4. Cayer, D.: Prolonged Anticholinergic Therapy of Duodenal Ulcer. Am. J. Dig. Dis. 1:301-309 (July) 1956. 5. McGlone, F. B.: Personal Communication to Lederle Laboratories. 6. Texter, E. C., Jr.: Personal Communication to Lederle Laboratories. 7. Bauer, H. G. and McGavack, T. H.: Personal Communication to Lederle Laboratories.

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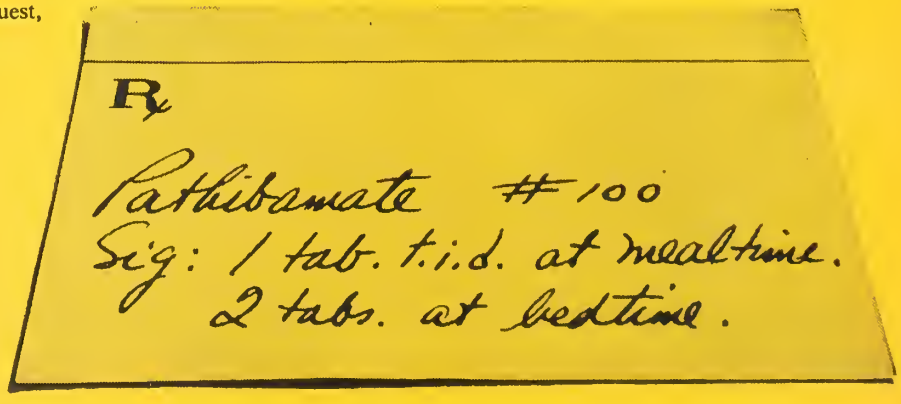


The Fourth Estate Looks at Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

FEDERAL PSYCHOSIS?

Medical practice is not our business, but an item about it in the morning newspaper has struck our eye, and we think it worth noting.

A young research psychiatrist has developed what is described as a "novel" treatment for schizophrenia. This disease is one of the most prevalent mental disorders. Our Webster defines it as "a type of psychosis charactrized by loss of contact with environment and by disintegration of personality." Many different treatments have been devised, most of them unsuccessful.

The researcher, Dr. Jordan M. Scher, has given 11 patients his treatment and six have shown improvement. His "novel" idea? Making the schizophrenics follow a "regimented work" schedule like normal individuals, after years in which they have done nothing for themselves.

Dr. Scher has a theory behind his treatment. In brief it is that the schizophrenic got that way not because he was rejected or overindulged by his parents, as is often asserted, but because he was "chronically underloaded" with work and responsibility.

Well, Dr. Scher has been ordered by his boss to end his "novel" research, on the stated grounds that it doesn't fit into a "well-balanced" research program.

Who is the boss that believes there is something "novel" and not "well-balanced" in work and responsibility? It is the National Institute of Mental Health. And that group is an arm of the Federal Government.

—*Wall Street Journal*

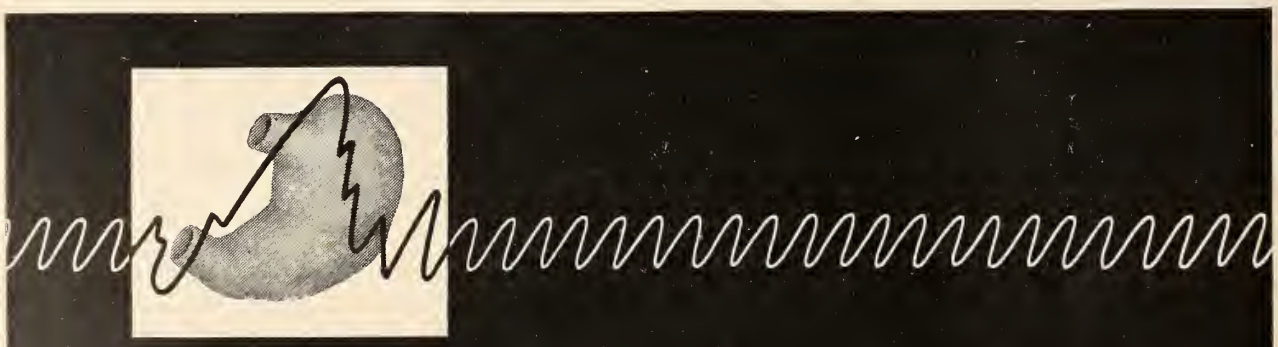
MEDICAL EDUCATION WEEK

Every time we call a doctor we acknowledge our debt to medical education. Every time we consult a specialist, send someone to the hospital, fill a prescription or take a drink of water—we pay a tribute to the nation's 82 medical schools.

The average American, it is safe to say, owes the

Continued

for "the butterfly stomach"



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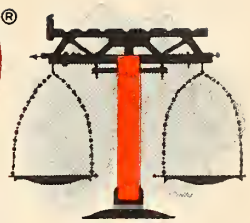
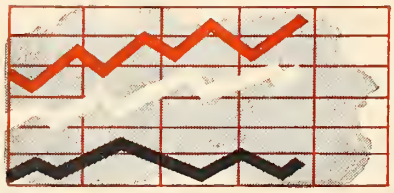


—new physiologic **iron chelate** for maximum  hematologic response—avoids interruption of therapy due to g.i. irritation —guards against iron poisoning from accidental overdosage

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last 21 years of his life to medical science. In 1900, life expectancy at birth was 49 years. Today it is 70.

Life-saving drugs and miracle cures appear in a steady procession. Infectious diseases everywhere are in retreat. Atomic science and nuclear physics are paving the way for new laboratory triumphs.

However, there is another side to the coin. The very medical progress of which we are so proud—and for which medical schools are primarily responsible—has involved the schools in a struggle for solvency that can affect the future health and welfare of the nation.

At stake is not only the ability of the schools to supply medical personnel and meet their current obligations, but also their ability to realize the full potential of the biological sciences and to fulfill new opportunities for advancing the nation's health.

During Medical Education Week, April 21-27, the National Fund for Medical Education is appealing to business and industry for $10,000,000 additional annual income for the medical schools.

Unless the schools get additional support, the people's demand for more doctors, more research, more services may go unheeded. Many talented young men and women may be denied an opportunity to learn medicine.

Industry has a direct self-interest in medical education. Industrial health programs and public health safeguards jointly pay dividends in increased efficiency, stepped-up man-hour production, reduced on-the-job illness and accident rates, reduced absenteeism, lowered insurance premiums and improved employe morale. Numerous before-and-after surveys of industrial plants show reduction to 50 per cent in absenteeism from illness and accidents.

Considering what may be at stake—the health and security of the American people—it is hard to think of a more worthwhile investment.

—*Kokomo Tribune*

IN THE NAME OF CHARITY

General Alfred M. Gruenther, who was chosen president of the American Red Cross upon his resignation as head of the North Atlantic Treaty Organization, reports that the Red Cross is in danger.

The General, an able organizer and administrator, is paid $30,000 annually by the Red Cross to see to its ministrations. The job is a vast and difficult one at best; the most difficult, however, seems to be the job of raising money. General Gruenther says that the annual campaign, which seeks funds for a $95 million budget this year, is some $20 million short of its goal.

Perhaps there are some reasons that go far beyond any reluctance to support the Red Cross as such. We think there are two that deserve some comment.

One is the growth of welfare programs in both the Federal and state governments. The Red Cross may be able to show no conflict between what it tries to do and what government tries to do; but that is not the point. The point is that a great many people are convinced that there is an overlapping of help and services.

The second point is inextricably mixed up with the first. The Red Cross is a charity appeal, but some of the appeal is lost when the public thinks that its taxes to some extent go for like purposes. Since taxes are as high as they are and are more likely to go higher than lower when city or county, state and Federal demands are added together, it finally becomes a question for a great many people of where is the money to come from?

The Red Cross is not alone in this predicament; Community Chests are also having a harder time raising the money necessary to carry on the services they provide. The inflated dollar adds to the costs, and adds to the budgets people are asked to support.

But when you get down to cases, the biggest trouble may very well be quite basic. When governments on every level insist on expending tax-collected dollars on charitable endeavors, true charitable organizations are bound to suffer. And the biggest sufferer of all under the system is Charity itself.

—*Wall Street Journal*

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Equally useless and dangerous is a "quantitative" urine-sugar test that does not quantitate dependably, or omits readings in the critical range.

Enzyme urine-sugar tests are sensitive and specific for glucose—excellent "yes" or "no" tests but undependable for quantitation. King and Hainline,[1] after testing 1,000 urines, found an enzymatic urine-sugar test unable to distinguish in the important range between ½ per cent and 2 per cent or more of urinary glucose. Leonards,[2] in a report on 4,020 tests, revealed that "...in 502 out of 804 tests the wrong interpretation was made." He concluded that enzymatic urine-sugar testing "...as a quantitative procedure is unsatisfactory and can lead to serious error in the interpretation of a patient's clinical condition."[2]

Failure to recognize this limitation of enzyme tests may result in incorrect insulin dosage,[2] and may lead to diabetic complications.

(1) King, J. W., and Hainline, A., Jr.: Commercial Glucose Oxidase Preparations for the Detection of Glucose in Urine, Cleveland Clin. Quart. 23:212, 1956. (2) Leonards, J. R.: Evaluation of Enzyme Tests for Urinary Glucose, J.A.M.A. 163:260 (Jan. 26) 1957.

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"Image Intensifier" Permits Safer, Better Diagnosis of Child Patients

A NEW METHOD of light amplification is being used at the Indiana University Medical Center, Indianapolis, to make x-ray motion pictures giving better and safer diagnosis of child patients.

An electronic device called an "image intensifier" amplifies the fluoroscopic x-ray image up to 2,000 times, making possible the taking of x-ray movies at speeds which are much more useful for diagnosis than the usual x-ray "stills." The image amplification also allows reduction of x-ray intensity, with less exposure of the patient and clinical workers.

The installation, which was financed by the Riley Memorial Association and is being used in Riley Hospital at the Center, is particularly useful for infants and young children because of the low x-ray intensity required and because movement by the subject during exposure does not harm the result.

The viewing area currently available is of small size (five inches in diameter) and consequently is useful on adults only for special applications. It is hoped that the device can be developed to observe larger areas.

The Riley Association has provided a special "film analyzing" projector for facilitating study of the x-ray movies by diagnosticians. This device is similar to those used by football coaches for reviewing games, and permits running of sections in slow motion, or prolonged study of individual frames as "stills."

The system in use by the Department of Radiology at the Medical Center is one of the first such installations which has been adapted to regular clinical application for the study of congenital heart disease in infants and children. It has aroused wide interest among radiologists with particular respect to its value in high speed radiography of the internal structure of the heart.

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Books: Received—

BOOKS RECEIVED

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

THE COMPLEAT PEDIATRICIAN: Practical, Diagnostic, Therapeutic and Preventive Pediatrics (7th completely rewritten edition). W. C. Davison, M.D., professor of pediatrics, Duke University School of Medicine, formerly acting pediatrician in charge, Johns Hopkins Hospital; and Jeana Davison Levinthal, M.D., instructor in pediatrics, University of Michigan School of Medicine. 13 chapters, 257 sections, completely indexed. Price $4.25. Duke University Press, Durham, N. C. 1957.

SICK CHILDREN: Diagnosis and Treatment. Donald Paterson, M.D., consulting physician to The Hospital for Sick Children, Great Ormond Street, London; revised by Reginald Lightwood, M.D., director, pediatric unit, St. Mary's Hospital Medical School, University of London, with the assistance of F. S. W. Brimblecombe, M.D., pediatrician, Royal Devon and Exeter Hospital, and Exeter City Hospital. 7th ed., 593 pp. illustrated. Price $8.75. J. B. Lippincott Company, East Washington Square, Philadelphia 5, Pa. 1956.

PAPER ELECTROPHORESIS: A Ciba Foundation Symposium. Edited by G. E. W. Wolstenholme and Elaine C. P. Millar. 22 participants, 74 illustrations. Price $6.75. Little, Brown and Company, 34 Beacon Street, Boston, Mass. 1956.

PROCTOLOGY. Harry E. Bacon, M.D., professor and head department of proctology, Temple University Medical School; Stuart T. Ross, M.D., attending proctologist, Nassau Hospital, Mineola; and Porfirio Mayo Recio, M.D., assistant professor of surgery, College of Medicine, University of Philippines. 441 pp., 223 illustrations. Price $10.00. J. B. Lippincott Company, East Washington Square, Philadelphia 5, Pa. 1956.

THE CARE OF THE EXPECTANT MOTHER. Josephine Barnes, D.M., F.R.C.S. (Eng.), assistant obstetrician and gynecologist, Charing Cross Hospital and Elizabeth Garrett Anderson Hospital, surgeon, Marie Curie Hospital. 270 pp., illustrated. Price $7.50. Philosophical Library, Inc., 15 E. 40th St., New York 16, N. Y. 1957.

ALLERGIC DERMATOSES DUE TO PHYSICAL AGENTS. Edited by Rudolf L. Baer, M.D., associate professor of clinical dermatology and syphilology, New York University Postgraduate Medical School. 110 pp., illustrated. Price $3.00. J. B. Lippincott Company, East Washington Square, Philadelphia 5, Pa. December 1956.

THE NEUROSES IN CLINICAL PRACTICE. Henry P. Laughlin, M.D., assistant professor of psychiatry, George Washington University School of Medicine, consultant in psychiatry, Walter Reed Army Medi-

and Reviewed

cal Center. 802 pp. Price $12.50. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa. 1956.

GENERAL UROLOGY. Donald R. Smith, M.D., clinical professor of urology and chairman of department of urology, University of California School of Medicine, San Franscisco. 328 pp., illustrated. Price $4.50. Lange Medical Publications, Los Altos, California. 1957.

PROCEEDINGS OF THE THIRD NATIONAL CANCER CONFERENCE. (1956). Sponsored by American Cancer Society, Inc., and National Cancer Institute, U. S. Public Health Service. 961 pp., illustrated. Price $9.00. J. B. Lippincott Company, East Washington Square, Philadelphia 5, Pa. 1957.

HANDBOOK OF PHYSICAL THERAPY. Robert Shestack, technical director, department of physical therapy, Washington County Hospital, Hagerstown, Md. 212 pp., illustrated. Price $4.25. Springer Publishing Company, Inc., 44 East 23rd Street, New York 10, N. Y. 1956.

THE YEARBOOK OF MODERN NURSING—1956. Edited by M. Cordelia Cowan, nurse, educator, author and editor; and Mary M. Roberts, editor emeritus, American Journal of Nursing. 446 pp. G. P. Putnam's Sons, New York 16, N. Y. 1956.

OBSERVATIONS ON KREBIOZEN IN THE MANAGEMENT OF CANCER. A. C. Ivy, M.D., distinguished professor of physiology and head of the department of clinical science, University of Illinois; John F. Pick, M.D., head of department of plastic surgery, Columbus Hospital, Chicago; and W. F. P. Phillips, M.D., department of general practice, St. Francis Hospital, Evanston, Illinois. 108 pp., illustrated. Price $2.50. Henry Regnery Company, 20 W. Jackson Blvd., Chicago 4, Ill. 1956.

MANAGEMENT OF EMOTIONAL PROBLEMS IN MEDICAL PRACTICE. Edited by Samuel Liebman, M.D., clinical assistant professor of psychiatry, University of Illinois College of Medicine, and director, North Shore Health Resort, Winnetka, Ill. 9 contributors. 152 pp. Price $5.00. J. B. Lippincott Company, East Washington Square, Philadelphia 5, Pa.

EXPECTANT MOTHERHOOD. 3rd ed., revised. Nicholson J. Eastman, M.D., professor of obstetrics in Johns Hopkins University, and obstetrician-in-chief to the Johns Hopkins Hospital. 198 pp., illustrated. Price $1.75. Little, Brown and Company, 34 Beacon Street, Boston 6, Mass. 1957.

RHEUMATIC DISEASES, RHEUMATISM AND ARTHRITIS. Heinrich G. Brugsch, M.D., assistant professor of medicine, School of Medicine, Tufts University. 330 pp., illustrated. Price $10.00. J. B. Lippincott Company, East Washington Square, Philadelphia 5, Pa. 1957.

BONE STRUCTURE AND METABOLISM. A Ciba Foundation Symposium. Edited by G. E. W. Wolstenholme and Cecilia M. O'Connor. 30 contributors. 299 pp., illustrated. Price $8.00. Little,

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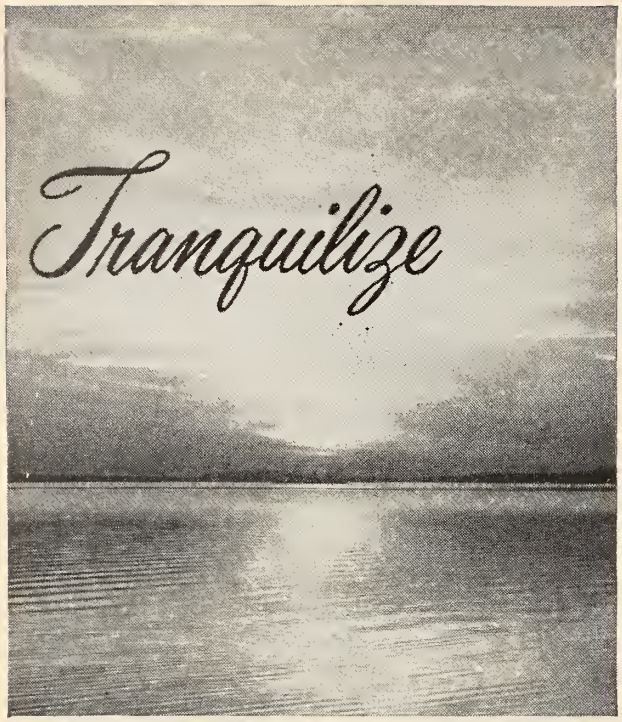

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Books (continued)

Brown and Company, 34 Beacon Street, Boston 6, Mass. 1956.

BATTLE FOR THE MIND. William Sargant, M.D., physician in charge of department of psychological medicine at one of England's oldest medical schools, and president of the Section on Psychiatry of the Royal Society of Medicine. 263 pp., illustrated. Price $4.50. Doubleday & Company, Inc., 575 Madison Ave., New York 22, N. Y. 1957.

SLEEP. Marie Carmichael Stopes, D.Sc., London. 154 pp. Price $3.00. Philosophical Library, Inc., 15 East 40th St., New York 16, N. Y. 1956.

PEDIATRICS. Edited by Donald Paterson, M.D., formerly clinical professor, department of pediatrics, The University of British Columbia; and John Ferguson McCreary, M.D., professor and head of department of pediatrics, The University of British Columbia, with 36 contributing authors. 654 pp., illustrated. Price $14.00. J. B. Lippincott Company, East Washington Square, Philadelphia 5, Pa. 1956.

BCG VACCINATION AGAINST TUBERCULOSIS. Sol Roy Rosenthal, M.D., director, Institution for Tuberculosis Research of the University of Illinois, and associate professor of preventive medicine, University of Illinois College of Medicine. 389 pp., illustrated. Price $7.50. Little, Brown and Company, 34 Beacon Street, Boston 6, Mass. 1957.

THE FIGHT FOR FLUORIDATION. Donald R. McNeil. 241 pp. Price $5.00. Oxford University Press, 114 Fifth Avenue, New York 11, N. Y. 1957.

MEDICINE IN CHICAGO, 1850-1950. Thomas N. Bonner. 302 pp., illustrated. Price $5.00. The American History Research Center, 816 State Street, Madison 6, Wisconsin. 1957.

TEXTBOOK OF MEDICAL PHYSIOLOGY. Arthur C. Guyton, M.D., professor and chairman of the department of physiology and biophysics, University of Mississippi School of Medicine. 1030 pp., 577 illustrations. Price $13.50. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa. 1956.

ESSAYS IN METABOLISM. The John Punnett Peters Number of the Yale Journal of Biology and Medicine, edited by Louis G. Welt, M.D., professor of medicine, University of North Carolina School of Medicine, Chapel Hill. 382 pp., illustrated. Price $6.50. Little, Brown & Company, 34 Beacon Street, Boston 6, Mass. 1957.

THE RIDDLE OF STUTTERING. C. S. Bluemel, M.D., Mount Airy Sanitarium, Denver, Colorado, Fellow of American College of Physicians, American Psychiatric Association, and American Speech and Hearing Association. 142 pp., illustrated. Price $3.50 casebound, $1.50, paper bound. Also available, 4 12" long-play speech therapy records at $3.00 each. All proceeds assigned to American Speech and Hearing Foundation. The Interstate Printers and Publishers, Inc., Jackson at Van Buren, Danville, Illinois. 1957.

SERVICES FOR CHILDREN WITH HEARING IMPAIRMENT and **SERVICES FOR CHILDREN WITH VISION AND EYE PROBLEMS.** Two new guides for public health personnel by the American Public Health Association. Manual on hearing has 124 pp.; manual on vision 112 pp. Price $1.50 each. Committee on Child Health, American Public Health Association, 1790 Broadway, New York 19, N. Y. 1957.

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Books (continued)

BOOKS REVIEWED

CIBA FOUNDATION SYMPOSIUM ON PAPER ELECTROPHORESIS. 224 pp. Little, Brown and Company, Boston. 1956.

Paper electrophoresis is one of the newer diagnostic tools. While the theoretical aspects are extremely complicated and shot through with higher mathematics, nevertheless the method has been put to practical clinical use in research centers. For instance, separation of human hemoglobin variants in studies on hemolytic anemia, sickle cell anemia, thalassemia and some others has been done. Analysis of sera from patients with rheumatoid arthritis was carried out before, during and after ACTH or cortisone administration, with reference to changes in protein-bound polysaccharides. Evaluation of the albumin-globulin ratio is the subject of a third contributor. A large part of the book is devoted to comparisons of different techniques and informal discussions of the various (16) papers, by the 22 exceedingly learned scientists who participated.

In perusing this symposium your reviewer realizes he is beyond his depth, as far as comprehension of techniques and most of the data are concerned; yet there is a little scientific thrill in being allowed a peek at the active development of one of the modern projects of prying open one of nature's "locked doors." To judge from the discussions at this symposium, the nature and variability of proteins are every bit as complex and confusing as we always thought they were.

A. W. CAVINS, M.D., Terre Haute.

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EXPECTANT MOTHERHOOD. Nicholson J. Eastman, M.D., professor of obstetrics in Johns Hopkins University; and obstetrician-in-chief to the Johns Hopkins Hospital. 3rd edition, revised. 198 pp. Little, Brown and Company, Boston. 1957.

This work, of course, has been so well known for so many years one would think a review of it superfluous. Yet it should be borne in mind that the last 10 years have seen numerous advances in obstetrics, and some controversies, and it is indeed 10 years since the second revision of this handbook. In his preface the author makes a significant statement, —one which should make us pause and ponder: "Having a baby today, provided that you are in the hands of a competent doctor, is a much safer undertaking than a long automobile trip." The **proviso re** the doctor is characteristic of the entire book and constitutes one of the elements of its superiority over so many "guides" in medical matters written by laymen.

Especially interesting is Dr. Eastman's analysis of so-called "Natural Childbirth." In less than 500 words he presents the essence of this subject, tells the expectant mother how to realize the advantages of its main principles, and then sums up in a short sentence which should itself promote confidence of the patient in her doctor: "Actually, all good doctors have been following the main tenets of Natural Childbirth for years." This is an example of the tact exhibited throughout the book, and if there is one quality needed in caring for and instructing expectant mothers, it is tact.

A. W. CAVINS, M.D., Terre Haute.

Walter Hines Page, noted editor and statesman, received a manuscript while he was editor of "World's Work" from an aspiring woman writer. The submitted article was rejected.

"Aha," the woman wrote back. "You didn't even read the manuscript. I had several pages glued together, and they have not been touched." She proceeded to give Page and the "World's Work" a good going over, accusing them of fraud and unfairness.

In his courteous reply Mr. Page admitted that the entire manuscript had not been read, but—

"When I crack a bad egg, it isn't necessary for me to eat the whole egg to find out that it is bad."

Medical Panorama—

A. W. Cavins, M. D.
Terre Haute

WORTHWHILE PROJECT

If you are looking for a new field of usefulness or improvement in service by your hospital or county medical society, the new poison information center at Pittsburgh should be highly stimulative. Notice of it, published in the *Bulletin of the Allegheny County Medical Society,* speaks for itself.

POISON INFORMATION CENTER

A Poison Information Center has been established at Children's Hospital under the sponsorship of the Allegheny County Health Department and under the direct supervision of Doctor Loren G. MacKinney, Director of the Out-Patient Department of the Hospital.

The Center will provide information concerning the composition of trade products, coordinate its activity with that of other centers in the accumulation and distribution of such information, call upon other resources in the community when necessary, and give advice regarding treatment. It has recently acquired a consulting staff of specialists in toxicology, pharmacology, botany, and other fields related to poisoning. Its service is available to physicians only, on a twenty-four-hour basis; calls from other sources will not be accepted because of possible resultant medico-legal involvement.

The ever-increasing number of toxic substances to be found in the home makes it impossible for the individual physician to keep informed 100% in the field, and such a service should prove invaluable, particularly in pediatrics.

ADDENDUM

To stress the growing importance of the problem discussed in Dr. Cavins' Medical Panorama, the following excerpt from an article published in the *Schering Science Bulletin* is reprinted here:

POISON CONTROL CENTERS

Because most pediatric emergencies are associated with accidental poisoning, poison control centers already have been developed in 23 cities throughout the country and plans are under way to establish a statewide network in 15 Florida cities and towns.

Centers are located in Phoenix, Ariz.; Denver, Colo.; Washington, D. C.; Chicago and Springfield, Ill.; Indianapolis, Ind.; Louisville, Ky.; Baltimore, Md.; Boston and New Bedford, Mass.; Grand Rapids, Mich.; Kansas City, Mo.; Atlantic City, Montclair and Newark, N. J.; New York, N. Y.; Durham, N. C.; Oklahoma City, Okla.; Harrisburg, Pa.; Memphis, Tenn.; Dallas, Tex.; Seattle, Wash.; and Milwaukee, Wis.

Recent reports from centers in 13 cities reveal that of 3877 cases, 2532 were in children under five years of age, reports Dr. Edward Press, Chairman of the Subcommittee on Poisoning of the American Academy of Pediatrics' Accident Prevention Committee. Of these, 955 children ingested internal medications—aspirin, laxatives and sedatives—in which death resulted for 3 children; 188 ingested external medication nonfatally; and 1389 ingested cleaning agents and other chemicals.

In the last group 17 were fatally affected by the materials ingested including lye, kerosene, other petroleum distillates, pesticides, paints containing lead, and some unknown substances.

"The general purpose of the centers is to minimize the damage to children from ingestion of potentially toxic substances; to coordinate the various types of general and specific treatment measures required in the hospital, the physicians' office, and the patient's home; and to make resources for treatment more readily and widely available," the public health physician explained.

PRESS, E.: Poison control centers, *Nursing Outlook* 5:29 (Jan.) 1957.

And in the April issue of the *Virginia Medical Monthly* a guest editorial is published concerning the establishment of still another poison information center in Richmond, Virginia. It says in part:

"In 1956 there were reported 138 fatalities in Virginia due to the ingestion of common, more or less 'every day' solid and liquid household articles. Of these, 102 were accidental . . . Based on national figures about 30 per cent of all fatal accidental intoxications occur in children under five years of age. Because of the obvious relationship of such a situation to pediatric practice, and recognizing the importance of a systematic approach to it, pediatricians, led to a large degree by the Committee on Accident

Continued

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Tolerance to this combination is good because there is little likelihood of sodium retention, potassium depletion or gastric distress with buffered prednisolone, and meprobamate rarely produces significant side effects in therapeutic dosage.

An additional important therapeutic benefit, often overlooked, stems from the tranquilizing action of meprobamate. This component of MEPROLONE relieves mental tension and anxiety so often manifest in arthritics, making them more amenable to other rehabilitation measures.

INDICATIONS: A wide variety of conditions, in which four symptoms predominate: *a)* inflammation *b)* muscle spasm *c)* anxiety and tension *d)* discomfort and disability; i.e., rheumatoid arthritis, rheumatoid spondylitis (Marie-Strümpell disease), Still's disease, psoriatic arthritis, osteoarthritis, bursitis, synovitis, tenosynovitis, myositis, fibrositis, fibromyositis, neuritis, acute and chronic low back pain, acute and chronic primary and secondary fibrositis and torticollis, intractable asthma, respiratory allergies, allergic and inflammatory eye and skin disorders (as maintenance therapy in disseminated lupus erythematosus, periarteritis nodosa, dermatomyositis and scleroderma).

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Steroids	✓	✓			✓
MEPROLONE	✓	✓	✓	✓	✓

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Prevention of the American Academy of Pediatrics, have played an active role in bringing about the establishment of facilities for the better dissemination of information on the nature of potentially poisonous preparations and indicated treatment if poisoning does occur. From the efforts of this group and several others, some 25 to 30 so-called 'Poison Information Centers' have been developed throughout the country. The first was organized in Chicago in 1953 with Dr. Edward Press as Director. . . .

"The Poison Information Center is not intended to be a facility for the actual treatment of poisoning; this aspect of the problem is quite adequately provided for by the emergency rooms of the local hospitals. The primary function of the Center will be to supply, on the request of physicians' information as to the constituents of a suspected preparation or plant as the cause of poisoning and possible guidance in treatment. When it is realized there are an estimated 250,000 'name' products alone available to the public about which the question of poisoning could arise, the importance to physicians of a ready source of information concerning their composition becomes apparent. . . ."

AND NOW, may we suggest you turn to the editorial pages and read what Indiana has done to meet the problem of accidental poisonings from ingestion of readily available products. You'll find it in "What to Do After the Doctor Arrives."

MEDICAL PRODUCTIONS GET TV-FILM RECOGNITION

"Even for One," AMA's new filmed dramatic show, received first place in the Golden Reel Film Festival at the fourth annual American Film Assembly in New York City. The 30-minute presentation won over 14 other entries in the institutional promotion division.

Winners of the Albert Lasker journalism awards "for outstanding reporting on medical research and public health during 1956" went to two CBS-TV programs —"Out of Darkness" (on mental illness) and "The Wassaic Story" (on mental retardation).

Two of seven women broadcasters selected for the McCall's "Mike" award were honored for public service involving medicine. Lee Phillip, Chicago, was recognized because of her efforts to encourage inoculation with Salk vaccine, and Ida McNeil, Pierre, South Dakota, for her special broadcasts for hospital patients.

The Pennsylvania Medical Society's "Safeguard Your Health" campaign received first prize "for the best use of radio and TV during 1956" in the annual judging by the Pennsylvania Public Relations Society.

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Steroid-Nutritional Therapy Is Constructive Approach for the First Signs of Aging

Emphasis on Early Treatment Before "Damage" Is Done

The first subtle suggestions of physiologic deterioration should not be dismissed if serious somatic and metabolic disorders are to be avoided. Prompt institution of steroid-nutritional therapy may forestall and even reverse premature "damage" and help prolong the active life of the patient.

Some of the most common symptoms of declining gonadal function and nutritional insufficiency are vague pains in the bones and joints, easy fatigability, decreased muscular tone, loss of appetite, chronic mental fatigue and general malaise. In older patients, these complaints are frequently indicative of degenerative processes when they cannot be attributed to a specific cause.

The comprehensive formula of "Mediatric" is specifically designed to provide three therapeutic services: 1. *protect* general metabolic integrity; 2. *preserve* physiologic efficiency; 3. *prevent* premature damage.

"Mediatric" supplies estrogen and androgen in small amounts to exert a favorable influence on bone and protein metabolism,[1] restore muscle tone and coordination,[2] and increase the tensile strength of the skin.[3] The two steroids appear to have an additive metabolic effect, while their opposing action on sex-linked tissue minimizes the incidence of untoward reactions.

Dietary supplements, including essential B vitamins and ascorbic acid, ensure adequate nutrition, prevent moderate anemias, and maintain efficient enzyme systems. The mood elevating effect of a mild antidepressant helps restore emotional stability and increases mental alertness.

Recommended dosages: Male — 1 tablet or 1 capsule (or 3 teaspoonfuls) daily, or as required. Female — 1 tablet or 1 capsule (or 3 teaspoonfuls) daily, or as required, taken in 21 day courses with a rest period of one week between courses.

Bibliography on request.

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d-Desoxyephedrine HCl	1.0 mg.

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"Mediatric" Liquid

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Conjugated estrogens equine ("Premarin"®)	0.25 mg.
Methyltestosterone	2.5 mg.
Thiamine HCl (B_1)	5.0 mg.
Vitamin B_{12}	1.5 mcg.
Folic acid U.S.P.	0.33 mg.
d-Desoxyephedrine HCl	1.0 mg.

Contains 15% alcohol
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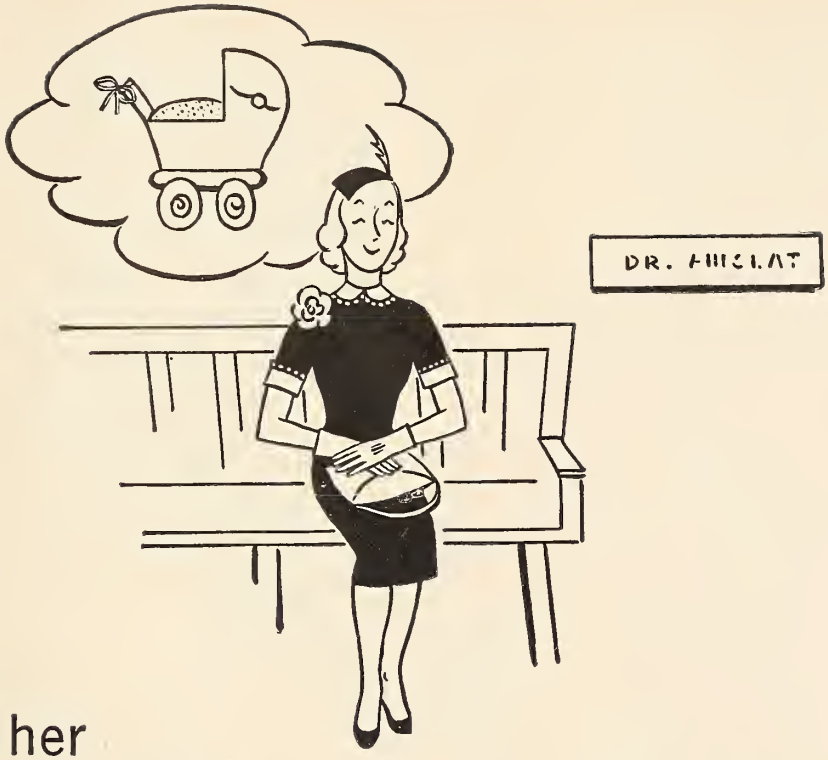

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Allergy to Common Ivy Reported; Suspects Sensitivity "Not Rare"

TWO CASES OF ALLERGY to Algerian ivy, a common house and garden plant, have been reported by a Pasadena, California, dermatologist.

Writing in the American Medical Association's May Archives of Dermatology, Dr. Clete S. Dorsey said he knows of no other reported cases of dermatitis from Algerian ivy.

After recovering from the Algerian ivy dermatitis, both patients became sensitive to the common English ivy, a close relative of Algerian ivy. This suggested that patients who have been sensitized by one of the plants will also be allergic to the other, he said.

Dr. Dorsey has a "strong suspicion" that contact dermatitis from the English and Algerian ivy is "not rare," since they are among the most widely cultivated of all plants.

Variants of English ivy grow throughout the United States. Algerian ivy, which has become quite popular in the last 10 years, grows outdoors only in the West Coast states. However, most of the large-leaved variegated house ivies are Algerian ivies and can be found anywhere in the country.

He noted that many plants are called ivies without being related to these "true ivies." For example: Kenilworth ivy, Boston ivy, German ivy (sometimes called Japanese ivy), ground ivy, marine ivy, Cape ivy, poison ivy, and philodendron (a common houseplant).

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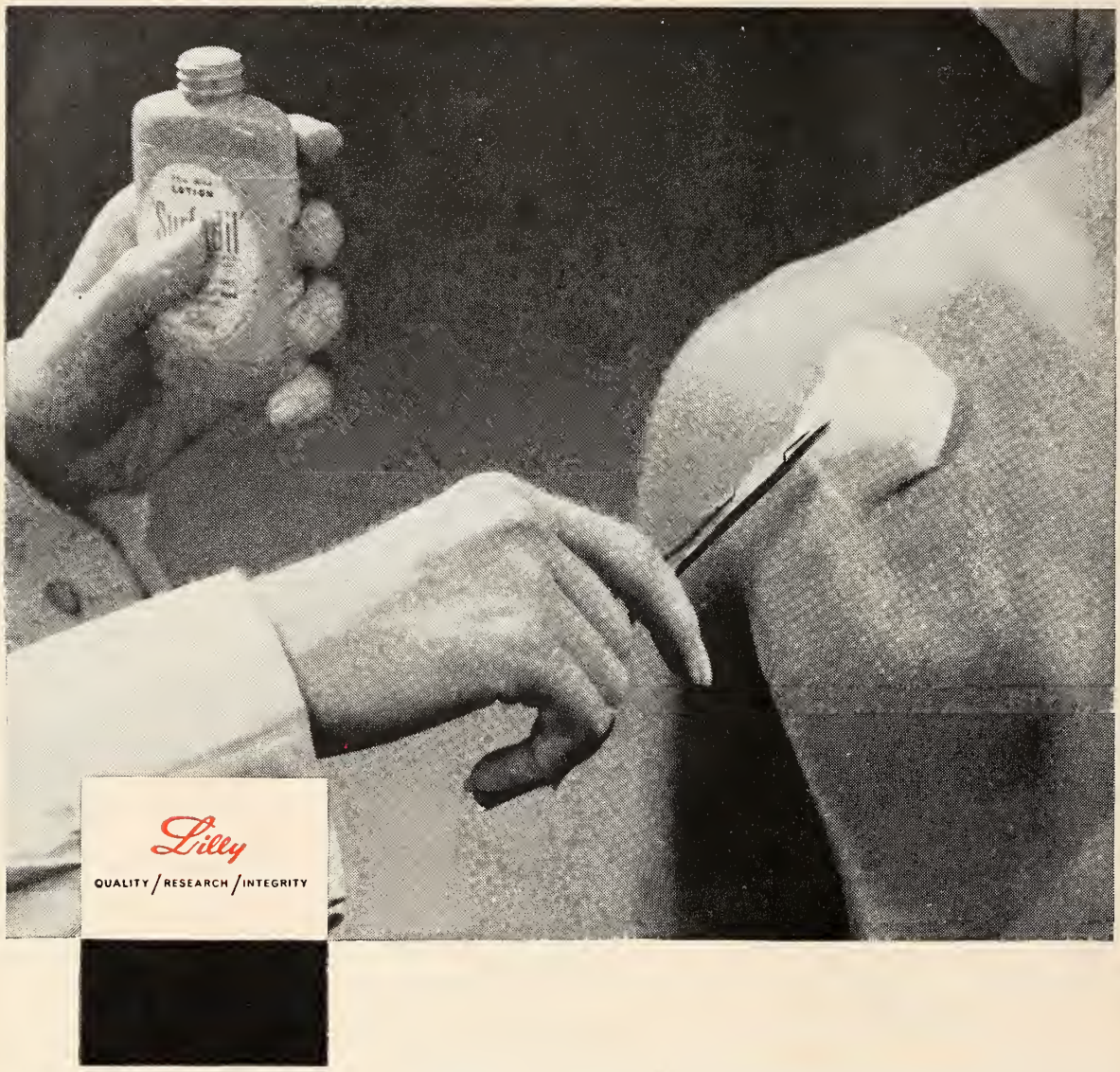

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

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Volume 50 — June 1957 — Number 6

Hyperfunction and Hypofunction of Endocrine Glands and Diabetes Mellitus

PENN G. SKILLERN, M.D.
E. PERRY McCULLAGH, M.D.
Cleveland

CLINICIANS ARE BECOMING aware that knowledge of the various factors affecting carbohydrate metabolism is important to a better understanding and better control—perhaps eventually the cure—of diabetes in the human being. Although the faulty carbohydrate metabolism that characterizes diabetes mellitus most frequently is traceable to dysfunction of the pancreas and resultant deficiency of insulin, other factors also play important roles in carbohydrate metabolism and their action sometimes causes diabetes or affects an existing diabetes.

Excessive production of hormones due to a pathologic condition originating from a number of endocrine glands may produce a diabetes which may be reversible if the pathologic cause is removed. In some patients the hyperglycemia, if sufficiently great or sufficiently long-lasting, may precipitate permanent diabetes due probably to true insulin deficiency.

From the Department of Endocrinology, The Cleveland Clinic Foundation, and The Frank E. Bunts Educational Institute, Cleveland, Ohio.

HYPERPITUITARISM AND DIABETES

Acromegaly: The diabetes of acromegaly is the clinical counterpart of experimental diabetes that is caused in animals by giving growth hormone. It is not possible to state with certainty in a given case whether an excess of growth hormone is the sole responsible factor, or whether this acts together with some excess of ACTH with excess of corticosteroids. Large adrenal cortices commonly have been found in acromegaly, and the studies by Venning and Browne[1] indicate that increased excretion of corticosteroids may occur. If excess ACTH is produced in acromegaly, one would expect the frequent development of Cushing's syndrome, but the two conditions rarely coexist. One case is reported by McCormick and associates.[2] The methods currently available for the estimation of excess

corticosteroids, and those most recently developed, have not yet been fully evaluated for acromegaly. It is to be hoped that the new methods of Sydnor and Sayers[3] for the determination of ACTH in blood will help to solve this part of the problem.

The incidence of diabetes in acromegaly has been variously estimated. The most frequently quoted figure is that of Coggeshall and Root[4] who reported that of 153 acromegalic patients, 35 per cent had glycosuria and 17 per cent had diabetes. We think it is fair to assume that many more than 17 per cent would have been classed as diabetic if glucose tolerance tests had been performed for all. It may be pertinent, however, that ACTH and cortisone cause glycosuria before hyperglycemia occurs as a result of their action.[5] Certainly it is not easy to relate the experimental facts with the low incidence of diabetes in acromegalic patients.

In our series of 76 acromegalic patients, 21 (28 per cent) were classified as diabetic. From the higher incidence it seems evident that mild diabetes, disclosed only by a glucose tolerance test, is present in many acromegalic patients or becomes clinically manifest.

The time lapse between the development of the first signs of acromegaly and the development of those of diabetes varies widely according to available figures. In Coggeshall and Root's[4] series, the time lapse ranged from 1 to 22 years and the findings of Goldberg and Lisser[6] are similar. Of the Clinic series of 21 acromegalic diabetic patients, in one patient the two conditions were diagnosed simultaneously, and in another there was a time lapse of 15 years between the diagnosis of acromegaly and that of diabetes; in the remainder, the time lapse ranged between these extremes.

Diabetes is said to occur much more commonly in women with acromegaly than in women in general. In our series there were 9 women and 12 men who were diabetic and acromegalic. In Coggeshall and Root's[4] series, the diabetes was much more common in those acromegalic patients who had family histories of diabetes.

Usually the diabetes that occurs in acromegalic patients is mild, but severe diabetes does occur. In Coggeshall and Root's[4] series, of the 16 patients who died, three died in diabetic coma. None in our series have had diabetic coma. Insulin resistance seems to occur more frequently in acromegalic diabetic patients than in the average diabetic patient; however, there are no accurate statistics to support this impression. We have under observation one acromegalic patient, a 48-year-old man, who requires a maintenance dose of 160 units insulin per day. Two other patients have required 220 and 175 units daily for brief intervals, but the usual requirement is in the range of 60 to 80 units.

The muscular wasting of acromegaly and the signs simulating amyotrophic lateral sclerosis do not parallel the severity of diabetes. The muscular weakness may be extreme, or actual amyotrophic lateral sclerosis may be present with very mild or no diabetes, or diabetes may be severe with no evident muscular wasting or weakness.

Diabetic retinopathy has been reported as occurring in acromegaly.[4] We have seen typical diabetic retinopathy in 3 of 21 acromegalic diabetic patients. One of the patients was a man who had had acromegaly for 12 years and diabetes for 8 years at the time retinal changes were first seen. His blood pressure was 160/100 mm. Hg. In another patient a few punctate hemorrhages were found; he was known to have had diabetes for only two years. His blood pressure was 110/60. The third patient was a 28-year-old man who had retinal hemorrhages that were actively recurring; he had been acromegalic for 10 years. He had had improvement in visual fields and apparent slowing of acral growth after removal of a pituitary tumor in 1944. However, he developed diabetes two years later—which was five years before retinopathy was found. His blood pressure was 120/90 mm. Hg. The type of renal failure seen in chronic diabetes, if it occurs, has not been recognized in our acromegalic patients. The paucity of cases of generalized vascular disease with renal failure may be related to the fact that most acromegalic patients die before their primary disease has lasted 15 years and that diabetes in them usually has existed for a much shorter time.

It is mentioned frequently in the literature that there is unusual variability in the severity of acromegalic diabetes. In a sense this is true, but in our experience in watching the progress of acromegaly for years we have been more impressed by the fact that in most such patients the diabetes is mild and peculiarly stable—vastly different in this respect from the diabetes of so many patients in whom we struggle daily to try to attain adequate control. It is equally true,

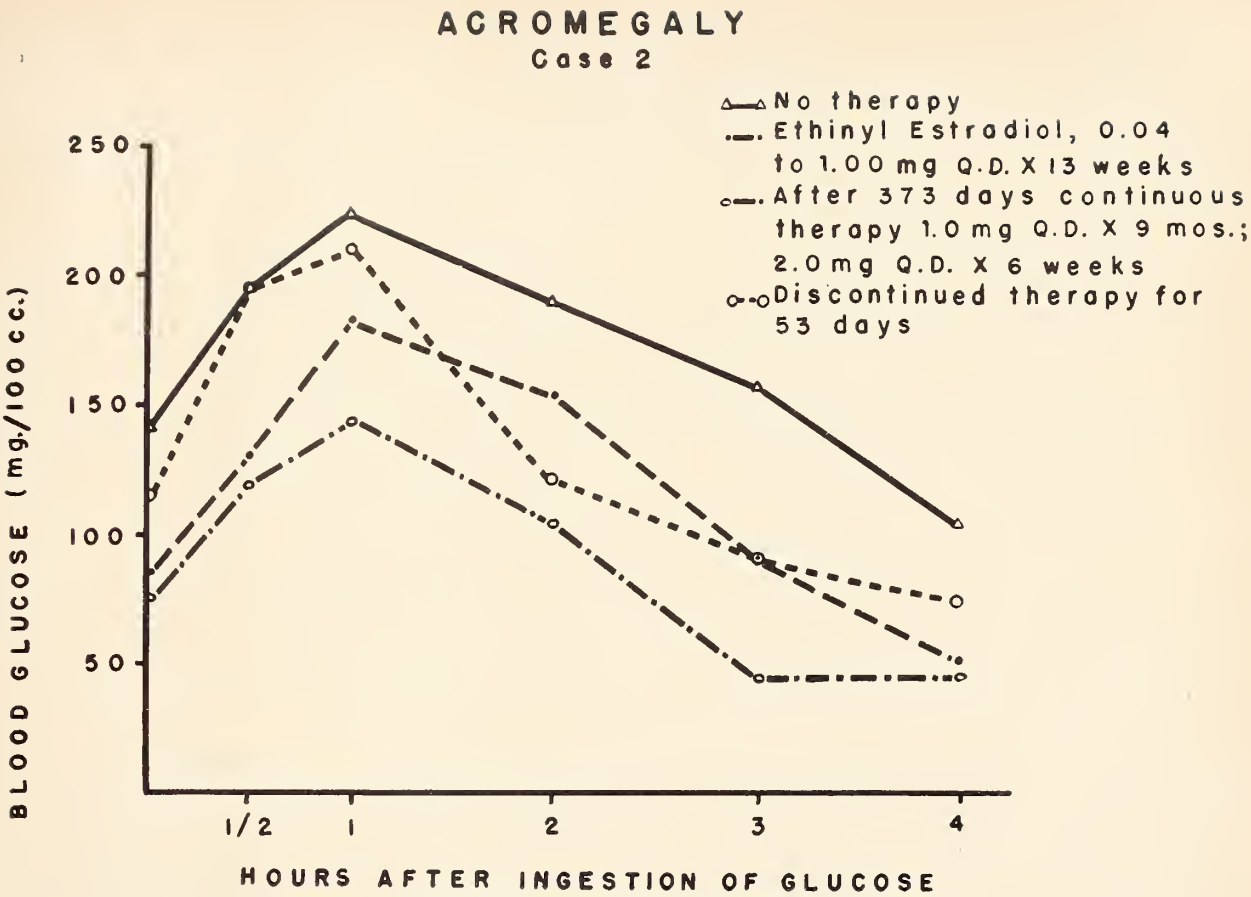

Figure 1. Glucose tolerance curves before, during, and after estrogen therapy.

however, that diabetes may show ingravescence during maintained pituitary hyperfunction, and slow or sudden amelioration with decline in hypophyseal function. However, Darragh and Shaw[7] reported the development of diabetes in acromegalic patients despite the apparent arrest of the acromegaly subsequent to roentgen treatment of the pituitary.

Almy and Shorr[8] reported the development of mastoiditis and basilar meningitis in a 40-year-old man who had had diabetes and acromegaly for five years. He had required 60 units of insulin daily. When evidence of pituitary failure developed, the glucose tolerance became normal and remained normal for five years. John[9] reported the spontaneous disappearance of diabetes in a patient having acromegaly.

Balfour and Sprague[10] reported the case of an acromegalic patient who had had blood sugar levels as high as 384 mg. per hundred milliliters and had required 62 units of insulin daily. Following roentgen therapy directed at the pituitary, an acute episode occurred that was thought to have resulted from rupture of an intrasellar tumor. Subsequently, 10 units of insulin daily controlled the blood sugar at a level of 147 mg. per hundred milliliters.

Recently, Gurling[11] in London reported the case of a 49-year-old acromegalic man who had diabetes with blood sugar values as high as 740 mg. per hundred milliliters and mild acidosis with severe coma and fever. The hyperglycemia was controlled with therapy. The temperature continued to rise, the coma continued, and the patient died. Hypoglycemia in this instance apparently did not develop, although death was associated with pituitary necrosis.

In the experience of one of us,[12] reversal of diabetes in acromegaly has been seen to follow long-continued therapy with estrogen. Of six acromegalic women, five had diabetes mellitus. In all it was mild, according to glucose tolerance tests. Very large doses of estrogen were used. Stilbestrol was given in doses of 10 to as much as 50 mg. per day or ethinyl estradiol 1.0 to 5.0 mg. per day, which is 20 to 100 times the usual dosage. The changes were slow, taking months to occur. Although the patients were not on carefully regulated diets we believe that the changes are significant because they were pro-

gressive; they were consistent in all five patients and in addition, after the glucose tolerance had become normal or nearly normal during therapy, cessation of treatment was followed in three cases by a recurrence of abnormal glucose tolerance (Fig. 1). That estrogen suppressed growth hormone production was indicated by soft-tissue shrinkage and a sustained lowering of blood phosphorus levels. The change in glucose tolerance, we believe, was due in part at least to diminished production of growth hormone and the sequence of events tends to confirm animal tests by a clinical experiment.

The effect of growth hormone upon diabetes in the human being has been studied in one patient by Kinsell, Balch, and Michaels.[13] A "highly purified" growth hormone preparation was used. Under controlled conditions this caused an increase in hyperglycemia and glycosuria and there were minimal evidences of ketonuria. The nitrogen balance changes also were minimal. The authors thought that these findings favored the idea that the effect of growth hormone was one that resulted more from interference with the utilization of insulin than from gluconeogenesis from protein breakdown.

HYPOPITUITARISM AND DIABETES

It is now 32 years since Olmsted and Logan[14] called attention to the fact that pituitary activity has a striking effect on animal sensitivity to insulin, and it is nearly 20 years since Houssay[15] reported his now-classical experiments on carbohydrate metabolism. Severe anterior pituitary failure superimposed on diabetes in the human being is a rare occurrence: perhaps a dozen outstanding cases have been reported.[16-24] It is remarkable that although the general effects of Simmonds' disease were severe in all of the patients, the effects on pre-existing diabetes differed markedly. In one patient a glucose tolerance, previously diabetic in type, became normal;[20] and in another the insulin requirement decreased from 60 to 43 units per day.[21] At the other extreme, there are those who develop hypoglycemia. In one patient "excessive glycosuria" disappeared after acute pituitary necrosis;[22] blood sugar levels fell to 31 and finally to 20 mg. per hundred milliliters. Another patient who had been taking 35 units of insulin daily, discontinued this dosage as pituitary cachexia developed; she died in hypoglycemic crisis.[16] Another patient who had required 60 units of insulin daily, had a similar course: after pituitary necrosis, hypoglycemic crisis developed; she died despite the intravenous administration of 60 grams of dextrose.

In instances of severe pituitary deficiency, sensitivity to insulin is very much greater than that seen in Addison's disease. This extreme sensitivity is dramatically illustrated in the case reported by Herstmann.[25] His patient was given intraveneously a test dose of 8 units of insulin; she developed hypoglycemic coma and died, despite intravenous administration of dextrose. Patients with hypopituitarism may have hypoglycemic reactions from as little as one unit of insulin given intravenously. The blood sugar levels in diabetes mellitus are only moderately decreased in Addison's disease and less than in anterior pituitary failure.

Hypophysectomy: Much interest centers about the effect of hypophysectomy on diabetes mellitus since Poulsen[18] observed the disappearance of all evidence of diabetic retinopathy in a 37-year-old woman after she had developed Simmonds' disease. The ocular signs consisted of punctate hemorrhages as well as larger retinal hemorrhages appearing as spots or stripes. There were a few remaining evidences of retinopathy four years after the development of cachexia. After seven years all evidences of that complication seemed to have disappeared.[18] Since that time, hypophysectomy has been performed upon some patients with diabetes, in an attempt to halt the progress or to alleviate degenerative disorders, particularly retinopathy. To date, the results have not been very encouraging.[26-29]

Cobalt Teletherapy: Recently we have attemped to produce hypopituitarism in patients having diabetes associated with severe retinopathy, by irradiation (exceeding 10,000 r) to the pituitary. Cobalt teletherapy* was used. As yet, we have produced no measurable pituitary deficiency. Except in patients having acromegaly, there has been no significant fall in insulin requirements, blood sugar levels, or urinary steroid titers.

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* The radioactive material used was supplied on authorization of the Isotopes Division, U. S. Atomic Energy Commission, Oak Ridge, Tennessee.

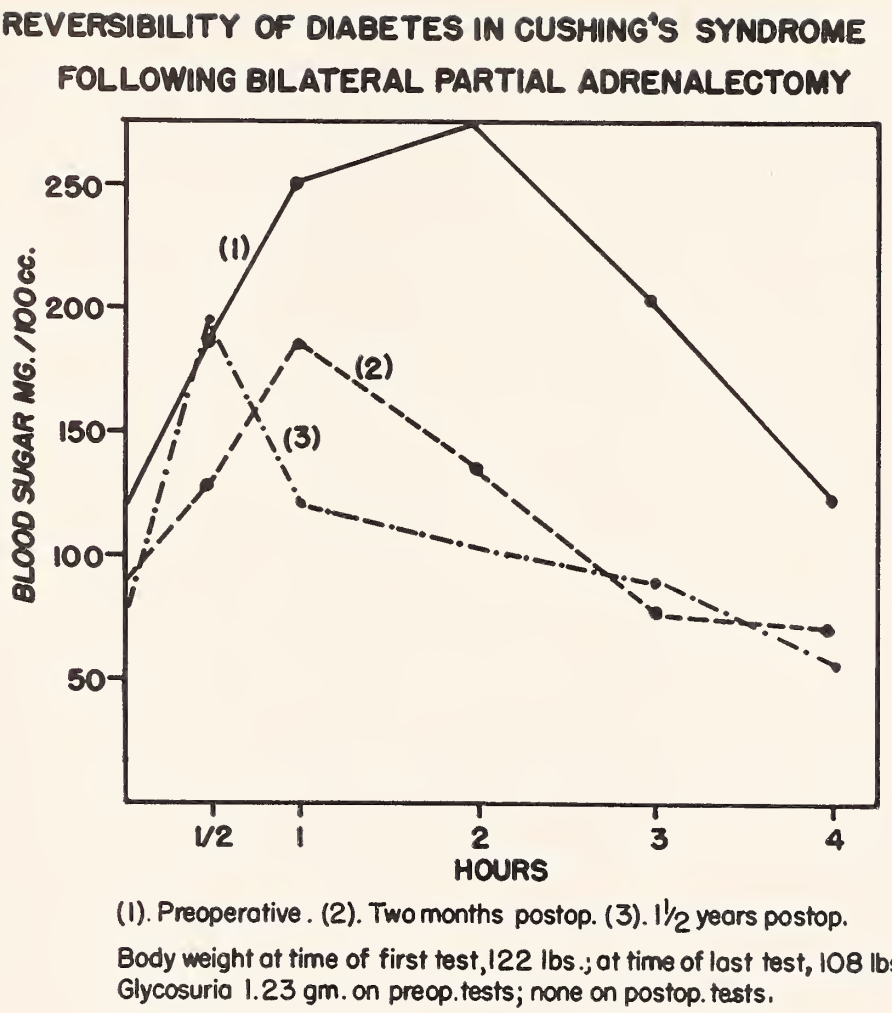

Figure 2. Reversibility of diabetes in Cushing's syndrome following bilateral partial adrenalectomy.
(1) Preoperative. (2) Two months postoperative. (3) One and one-half years postoperative.

THE ADRENAL GLAND AND DIABETES MELLITUS

Cushing's Disease and Diabetes: Steroid diabetes arising spontaneously is due to excessive production of hydrocortisone-like compounds by the adrenals. Those hormones cause glycosuria partly by decreasing the ability of renal tubules to absorb glucose.[30] They also interfere with the action of insulin, and cause glycosuria and hyperglycemia by impairing carbohydrate utilization and by augmenting the breakdown of protein. Clinically, such diabetes is relatively mild and insulin-insensitive, and is associated with a negative nitrogen balance that is not fully corrected by insulin. The diabetes usually disappears after the steroid excess has been corrected.

It is a remarkable fact that diabetes does not always occur in patients having severe Cushing's syndrome of long standing. Evidently, important protective homeostatic mechanisms are functioning in these cases and prevent the development of diabetes. We also have seen one patient who clinically had the adrenogenital syndrome with severe alkalosis but without diabetes.

Of 34 of our patients having Cushing's syndrome, 21 (15 women and 6 men) had diabetes. Insulin in dosages ranging from 8 to 90 units daily was prescribed for 7 of the 21 patients. Sprague and associates[31] reported that of 10 patients with Cushing's syndrome who had elevated blood sugar levels before operation, 7 had normal values for fasting blood sugar after operation.

In patients having Cushing's syndrome it is difficult to ascertain a diabetic origin of vascular complications since the hypertensive disease is an integral part of the condition.

Among our 21 patients with Cushing's syndrome, three had retinopathy. One of the three patients had a hemorrhagic retinopathy not typical of diabetes, and the blood pressure was 175/120 mm. Hg. The remaining two patients had what was classified as *diabetic retinopathy.*

The possibility that certain chemical features of the diabetes associated with Cushing's syndrome are different from those in the average case of clinical diabetes has been studied by Hills, Power, and Wilder.[30] They found that in

34 patients having typical mild diabetes without Cushing's syndrome, the blood lactate and pyruvate levels were not distinctly abnormal. In contrast, in four of six patients having diabetes mellitus and Cushing's syndrome, the blood lactate and pyruvate levels were markedly elevated before the administration of glucose for a glucose tolerance test and rose still further after the administration of glucose. Two of the six patients had hypokalemic hypochloremic alkalosis.

As mentioned previously, long-standing steroid diabetes may not cause permanent diabetes. For example, in one of our patients who had a glucose tolerance of diabetic type before adrenal surgery, the diabetes not only disappeared postoperatively when adrenal insufficiency supervened but the glucose tolerance became that typical of Addison's disease.

The fact that the steroid diabetes of Cushing's syndrome has *not* been shown to cause diabetic retinopathy more frequently than do other types of diabetes, may be partially attributable to variations in duration of diabetes: when diabetic retinopathy develops in a patient having Cushing's syndrome, the duration of the diabetes usually has been shorter than when diabetic retinopathy develops in a patient who does not have Cushing's syndrome.

It is unlikely that adrenocortical hyperfunction is a common cause of diabetes mellitus. The correction of steroid excess and/or the "cure" of Cushing's syndrome almost invariably result in the disappearance of diabetes (Fig. 2), and those patients who have been known to have adrenal deficiency superimposed on diabetes mellitus have persistent diabetes.

One of our patients had typical clinical Cushing's disease with pituitary tumor; the tumor was visualized roentgenographically and was proven at surgery. The diabetes disappeared after local application of radioactive cobalt* to the pituitary gland. Results of glucose tolerance tests before and six months after cobalt irradiation are presented in Table 1. Diabetes subsequently recurred and adrenalectomy was performed, but the patient died. He had a malignant tumor of the pituitary.

* The radioactive material used was supplied on authorization of the Isotopes Division, U. S. Atomic Energy Commission, Oak Ridge, Tennessee.

TABLE 1

RESULTS OF GLUCOSE TOLERANCE TESTS BEFORE AND AFTER COBALT TELETHERAPY IN PATIENT WITH CUSHING'S SYNDROME WITH PITUITARY TUMOR

Relation to treatment	Blood sugar, mg./100 ml.					
	Fasting	Time, hours p.c.				
		½	1	2	3	4
Before treatment	138	240	370	275	116	---
Six months after treatment	137	208	149	110	75	86

Exogenous Cortisone Administration and Diabetes: Sprague[32] in a review of the physiologic effects of cortisone on carbohydrate metabolism pointed out that increase in hyperglycemia in patients with pre-existing diabetes by this hormone may be due to a deficient insulin-producing mechanism. We also believe that the apparent onset of diabetes in a patient receiving cortisone is more likely due to aggravation of a preexisting latent or mild diabetes by cortisone rather than being due to the effect of cortisone alone. An important study by Fajans and Conn[33] describes the occurrence of a diabetic glucose tolerance curve in 18 of 75 relatives of diabetics after the administration of 100-125 mg. of cortisone. Previously, the glucose tolerance test had been normal in these persons. Only one of 37 control patients without a family history of diabetes had a diabetic glucose tolerance test after cortisone administration. Only further observation, as stressed by these investigators,[33] will determine whether these patients with diabetic glucose tolerance curves after cortisone administration will be diabetics in the future.

Pheochromocytoma and Diabetes: The following case report of a patient with pheochromocytoma describes the presence of diabetes mellitus with persistently elevated blood sugar values, diabetic acidosis, and paroxysmal hypertension. Removal of the pheochromocytoma resulted in a complete disappearance of the diabetes, as determined by the glucose tolerance test, and of the hypertension.

A 58-year-old woman was admitted to the Clinic in May 1956, with a three-year history of spells of palpitation, sweating, and epigastric distress with occasional headaches and vomiting.

Five months prior to admission the vomiting became progressively worse and was the chief complaint on admission. Her weight had decreased 25 pounds in the past two months with the onset of thirst, polyuria, and polydipsia.

Physical examination revealed a pale, drowsy, underweight, chronically ill woman. The blood pressure fluctuated from 60/30 to 230/130 mm. Hg.

Laboratory tests initially indicated the blood sugar level to be 543 mg. per hundred milliliters, urea content 60 mg. per hundred milliliters, and CO_2-combining power 11 mEq. per liter (normal, 27 mEq. per liter). The urine showed four plus sugar, four plus acetone, and the presence of diacetic acid.

Treatment with insulin and fluids corrected the acidosis. A subsequent blood CO_2-combining power value was 20 mEq. per liter the next morning. Nine subsequent blood sugar values ranged from 186 to 277 mg. per hundred milliliters, and a dose of 30 units of NPH insulin (Fig. 2) daily was required to control the glycosuria. The basal metabolic rate was plus 14 per cent.

The histamine test and Regitine test were positive for pheochromocytoma. A pheochromocytoma and the right adrenal gland were removed. Postoperatively, blood sugar levels were 111, 89, and 104 mg. per hundred milliliters. Within two months all evidence of the diabetes mellitus had disappeared. The glucose tolerance test was normal (Fig. 3). The blood pressure was 110/70.

Aldosteronism and Diabetes: Hewlett, one of us (E. P. McC.), and associates[34] reported two patients with primary aldosteronism due to cortical adenoma who also had diabetes mellitus. One patient had a diabetic glucose tolerance curve which reverted to normal after removal of the tumor (Fig. 4). The other patient had moderate diabetes mellitus with initial fasting and two and one-half hour blood sugar levels of 309 and 406 mg. per hundred milliliters respectively. The diabetes was greatly ameliorated by removal of cortical adenoma, but the glucose tolerance was still abnormal even though the fasting blood sugar level was 107 mg. per hundred milliliters.

Hyperthyroidism and Diabetes Mellitus: The question as to whether a diabetic glucose tolerance curve which is reversed to normal by correction of the hyperthyroidism is actually diagnostic of diabetes has not been settled. In some instances the diabetic glucose tolerance curve may be due to a flare-up of a latent diabetes, especially in those patients with a diabetic family history. Such a diabetic curve may be due to poor nutrition, rapid absorption, or liver dysfunction.

However, the occurrence of an elevated fasting blood sugar level with hyperthyroidism is indicative of diabetes mellitus in our experience even though the fasting blood sugar or glucose tolerance may return to normal. As has been previously pointed out by John,[35] in most patients the diabetes is definitely improved upon diasappearance of the hyperthyroidism or the diabetes may remain unchanged. In some instances,

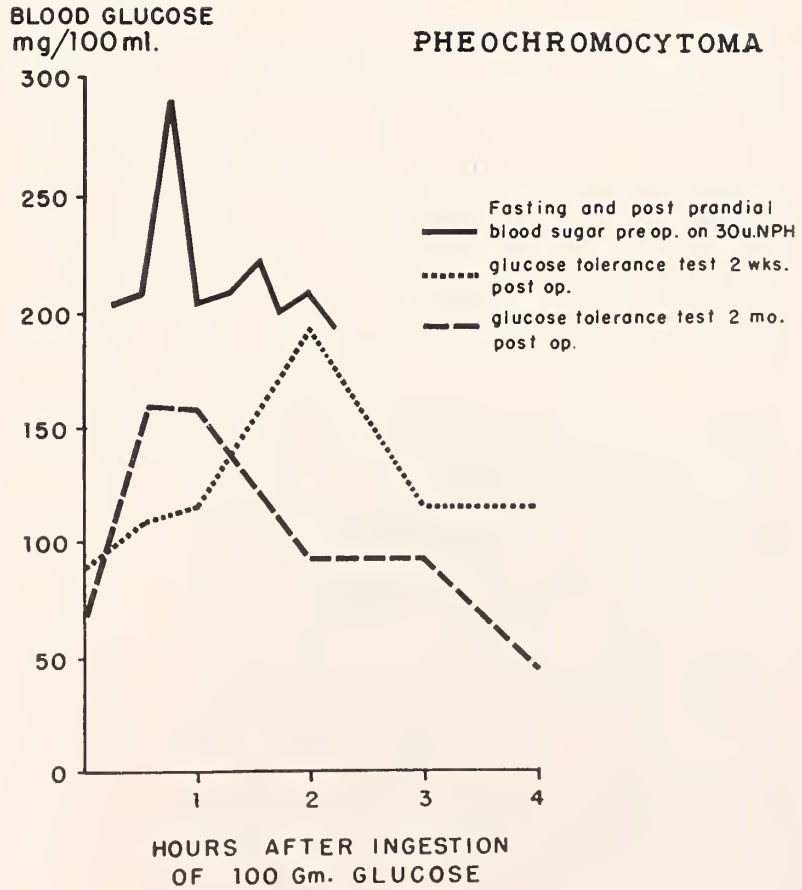

Figure 3. Reversibility of diabetes after removal of a pheochromocytoma.

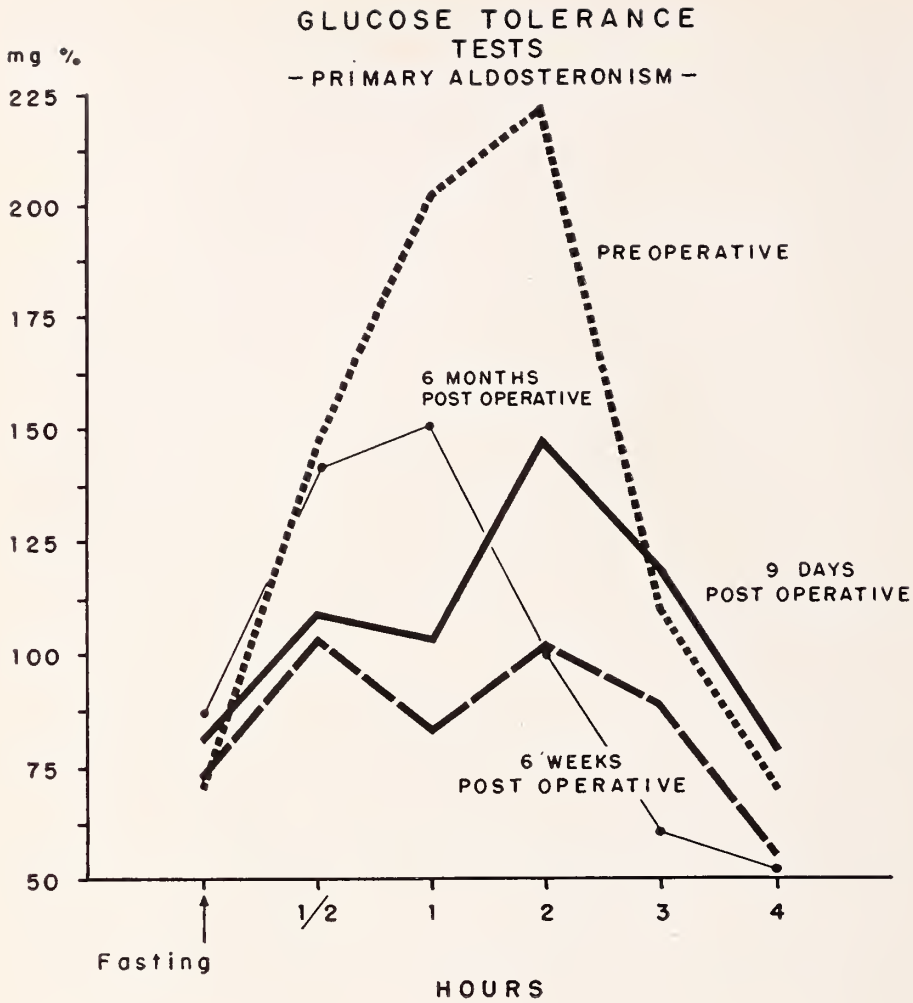

Figure 4. Reversibility of a diabetic glucose tolerance curve after removal of an adrenal tumor in a patient with aldosteronism. Note that a flat glucose tolerance curve occurs immediately postoperatively, probably due to residual suppression of the adrenal glands by the secretion of the removed tumor. The glucose tolerance curve later is more normal.

the diabetes may be worse than before the onset of hyperthyroidism. Hypothyroidism produces only a slight decrease in blood sugar in the diabetic.

SUMMARY

Diabetes mellitus may be precipitated by hyperfunctioning tumors of the pituitary, adrenal cortex, adrenal medulla, thyroid, and hyperplasia of the adrenal cortex and thyroid.

After surgical correction of the pathologic condition, the diabetes may or may not be reversible. Instances of reversible diabetes with acromegaly due to spontaneous causes, cobalt treatment, and estrogen therapy are described. The diabetes due to Cushing's syndrome is usually corrected by surgical removal of the tumor or hyperplasia of the adrenal cortex.

One patient with Cushing's syndrome and pituitary tumor had a temporary remission of the diabetes after cobalt irradiation of the pituitary. The diabetes mellitus of one patient with pheochromocytoma who was admitted in diabetic acidosis, disappeared after removal of the pheochromocytoma. The occurrence of diabetes mellitis in two patients with aldosteronism due to adrenal tumor suggests that a hormone may be secreted which has some corticoid action. Marked hyperglycemia during the administration of cortisone or permanent diabetes mellitus following the administration of exogenous cortisone is probably due to a pre-existing latent or mild diabetes mellitus.

A diabetic glucose tolerance curve in a patient with hyperthyroidism may or may not be due to diabetes mellitus. An elevated fasting blood sugar in the presence of hyperthyroidism is due to diabetes mellitus.

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The Management of Certain Disorders of the Lower Back*

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IT MIGHT WELL BE SAID at the outset that a good many of the disorders occurring in the low back pose a problem in management rather than cure. The implication intended is that a significant number of them are neither sufficiently self-limited, nor so responsive to treatment that a permanent resolution of symptoms can be logically anticipated. Since this is the case it is usually necessary to view a low back problem in a most circumspect manner, and to consider not only what is the altered anatomy and physiology, but also to what degree it is correctable and what will be the effects upon it of the every day activities in which the patient currently must indulge.

The entities which we will consider usually manifest themselves (as do most back disorders) by aching or pain, both local and referred: by stiffness, or by such bizarre complaints as painful fore feet. Occasionally the patient may complain of some gross postural deformity such as dorsal kyphosis.

With these rather nebulous complaints it is our problem to ferret out which of the several possible disorders is present and to provide as effective a program as possible for its elimination or management. This portion of your panel will consider the following entities:

I. Acute back strain.
II. Congenital abnormalities-spina bifida occulta, spondylolysis, etc.
III. Postural backache.
IV. Degenerative joint disease.
V. Spondylolisthesis.

I. Acute strains are among the most common of back disorders and many of them do not even come to medical attention. When a previously healthy person, not given to chronic back trouble, can relate a sudden pain in his back to some unusual effort (be it an unusually heavy load or a compromised position while lifting) we may conclude that he has strained his back. But this, too, is nebulous, for the back is an area of the body. Just what has been strained? I believe that there usually occurs a stretch or actual tear of a myofascial or ligamentous structure at its insertion or origin about the spine or upper pelvic rim. Such lesions, momentarily painful, are subsequently the site of hemorrhage and edema. Here, as in the sprained ankle, symptoms may be considerably more pronounced or even incapacitating 8 to 12 hours later, and the patient may only discover this fact upon arising the morning after. The essential of treatment in this disorder is rest to the point of symptom resolution. Some form of physical therapy such as heat may hasten recovery by the alleviation of symptoms, but no more than that. It is always wise to obtain x-rays to rule out fracture. If present, fractures are most frequently in the transverse processes but treatment is not essentially altered, only prolonged until the patient is comfortable upon moving about.

Compression fracture of the vertebral body poses another problem not to be considered here —except to rule it out. Should the symptoms persist in this situation observation and repeated examination may reveal some hitherto occult or quiescent disorder made symptomatic by the incident.

II. Congenital variations in vertebral structure, particularly in the lumbosacral area, are very common and in the first 3 or 4 decades of life do not show a clear-cut correlation with low back symptoms. Among the common varia-

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tions observed as incidental findings in spine films are spina bifida, asymmetry of facets, lumbarization of the first sacral segment and the reverse, sacralization of the fifth lumbar vertebra. A common unilateral (at times bilateral) defect may occur in the so-called pars interarticularis. Here the pedicle and superior facet are not joined by bone to the lamina and inferior facet of the posterior neural arch. The defect is termed spondylolysis. But such defects are not primarily the source of symptoms. Rather it is that they may predispose through faulty articulation either to early symptomatic degenerative joint disease, or, in combination with poor posture to chronic low back ache. This culmination in symptoms of a combined disorder is not unusual.

III. Having introduced two disorders let us now consider so-called postural backache. The victim may or may not have a congenital variation in his vertebral structure, but certainly he has the same spine that was previously asymptomatic. An x-ray may show a sharper than average lumbosacral angle, yet in my experience this finding does not always correlate clearly with symptoms though it does have portent. Physical examination will usually show, in addition to some local tenderness, a definite lordosis, and the history may reveal that relief attends recumbency. But other points deserve attention here. Has the patient a dorsal kyphosis and if so, why? Is he obese and pot-bellied? Do the balls of his feet hurt when he stands? All of these additional findings suggest that his center of gravity has been shifted forward, and in order to retain his upright position he simply hyperextends his lumbosacral spine. A physiological example is to be noted in the pregnant female near term. But even beyond this point we might consider whether this attitude is due to lassitude or loss of muscle tone, or to some basic muscular or neuro-muscular disorder such as myasthenia gravis. While we have emphasized the fault in standing posture, it is well to know also about the patient's body attitudes at his work or in everyday activities. How does he lift, bend and sit? These may be equally faulty and unless corrected result in the extension of his symptoms into the lower extremities by compromising the spinal nerves as they emerge from the lordotic area of his spine. The very analysis of this type of back pain suggests a clue to its elimination by correction of the faulty posture.

May I say here that the sacroiliac joint as a point of painful disorders has been reemphasized in some recent literature. This reconsideration of that structure has been published in monograph form. Some orthopedic surgeons have tried the injection materials and techniques advocated in the book, and while they were forced to acknowledge some excellent results, they were by and large uncertain of the results as a whole. I believe it should be pointed out that the sacroiliac joint, which is so beautifully locked and stable when the pelvis is in its normal attitude, loses much of that intrinsic strength when the pelvis rolls forward into the lordotic attitude. Therefore some of the chronic symptoms alleged to arise from this disordered joint may well be benefited by correction of faulty pelvis posture.

IV. The term degenerative joint disease will soon displace the older term of osteoarthritis, though they are synonymous. Believing this, I shall use the former term. Degenerative joint disease when occurring in the spine may be either localized or generalized. All skeletal joints fall victim to degenerative changes if a man lives long enough. Yet not all are symptomatic. Such is the generalized disorder which may affect the entire spine but in varying degrees in its various portions.

The localized variety, often confined to one intervertebral system and its joints, may occur in most any age group and often is the final expression of some previous trauma, such as a degeneration or extrusion (partial or complete) of a nucleus pulposus. Such extrusions do not always give rise to radicular symptoms.

While osteophytes at the edges of the vertebral bodies are easily the most dramatic X-ray findings in this disorder, there is considerable doubt that these precise outgrowths are responsible for many of the attendant symptoms. Such osteophytes are far too frequently observed as incidental findings in the X-rays of persons whose spines are asymptomatic. But their presence always implies that degenerative symptoms are present in the adjacent zygapophyseal joints. While a fracture through a large marginal osteophyte may well give rise to an acute episode, it is to the disordered zygapophyseal joints that we would look for an explanation of chronic symptoms. These joints have articular cartilage surfaces which may be eroded, synovium to be

irritated by small marginal osteophytes, and capsules to become stiff and fibrotic with chronic recurrent irritation, and there are nerve endings to transmit the pain thus induced.

In degenerative joint disease the most common presenting complaint is painful stiffness, often marked, which follows a period of rest. Thus stiffness may be most intense upon arising in the morning. A sense of loosening up may follow the first few painful moves and not infrequently by mid-day the patient is quite comfortable. But aching soon supervenes and with fatigue at the day's end may be quite intense. Repeated bending will aggravate, while a sudden move or a strain may precipitate an acute attack to the point of temporary disability.

Suprisingly, patients with either of these two types may show deceptively good ranges of motion if they are not having an acute episode. X-ray findings in the localized variety quite regularly will show some loss of the intervertebral disc space, with sclerosis of the adjacent body surfaces. Spurring may be excessive or nearly absent. But oblique views of the involved segment often show similar changes in the zygapophyseal joints themselves.

V. *Spondylolisthesis* is by definition a forward displacement of one vertebral body upon the one immediately beneath it. It varies widely in the degree of displacement. Rarely is it complete. Once it was considered always to be the result of bilateral spondylolysis of congenital origin, therefore present from birth or before, but tending to become symptomatic only in the late second or early third decade of life. Then a so-called weak back developed and was evidenced by frequent acute episodes of back pain, often culminating in chronic backache, with or without associated radicular pain into the limbs. This is a very common pattern of course. When displacement is gross it may be strongly suspected upon physical examination, but it remains for the x-ray to demonstrate its presence conclusively. In this variety the anterior and posterior neural arches are independent units, separated from each other to variable degrees.

However, other causes for spondylolisthesis have been demonstrated and among them insufficiency of the superior articular facets of the sacrum, perhaps of a congenital origin, perhaps degenerative. In this pattern the displaced fifth lumbar vertebra is intact—a single unit—with no separation of its anterior and posterior neural arches. The symptoms may be the same as before, but the age incidence is later as a rule. In the older patient degenerative joint disease of the zygapophyseal joints may result in instability and spondylolisthesis. Such slipping is rarely marked, and also is as likely to occur at the L4-5 level as at the lumbosacral joint. Since it is coincident with degenerative joint disease, or a result of it, it is difficult to say which is the most likely cause of attending symptoms. Both probably.

Once a diagnosis for the backache has been definitely established specific treatment may be applied together with the general treatment measures which may have been used before the diagnosis was established. Always a carefully taken history and physical examination are necessary and appropriate x-rays must be gotten and interpreted. Yet while papers, and books and lectures seem to imply that accurate diagnosis is in fact quite elementary and simple, you all know that in practice such is not the case. While a logical working diagnosis is desirable, a definitive and final diagnosis may become evident only after prolonged observation. Such observation implies, of course, the maintenance of progress notes and repeated physical examinations. But the patient comes to the doctor with symptoms or signs or both and his desire is first of all to be rid of them. Diagnosis is the tool which when established indicates an appropriate treatment program. The patient's interest in diagnosis is simply to know first if it has portent, and secondly its associated prognosis in terms of the rapidity and completeness of recovery.

The most common symptom is pain. Its usefulness in diagnosis evolves around its variation in character, in pattern of distribution (i.e., local or referred) and in its relationship to specific activities or attitudes of the patient. Apart from protecting the spinal nerves, and serving as a point of origin or insertion for muscles, ligaments and tendons, the lower spine has two functions, at once combined. They are effective weight bearing, while permitting motion, and normally these are accomplished without discomfort. Pain during these acts usually implies a mechanical disorder. The affections of the lower spine we are considering are, by and large, expressed as mechanical derangements. This is implied since the symptoms which attend them

are usually greatest when the patient is up and active and less severe, or resolved, when the patient is at rest. Treatment in the main is directed toward relief of symptoms and prevention of recurrence by eliminating painful motion and improving postural mechanics. A list of the measures commonly employed might include the following:

1. Bed rest.
2. Weight reduction.
3. Physical therapy.
4. Manipulations of the spine.
5. Medicine:
   a. muscle relaxants.
   b. sedation.
   c. local anesthesia.
6. External supports—corsets, casts, braces.
7. Postural exercises and training.
8. Surgical intervention.

Probably the most useful single measure, especially in the acute phase of any of these disorders, is bed rest in the most comfortable position the patient can find. Both weight bearing and movement in the lower spine are largely eliminated so that local inflammatory processes are permitted to resolve without the interference of repetitive irritation. But if bed rest is to be fully effective it must be continuous, 24 hours a day, and of sufficient duration.

I would like to say now that I have had no very remarkable success with manipulation of the spine in any case. Further, unless one is absolutely certain that there is no danger of displacement or vertebral body collapse, these maneuvers are fraught with danger and the catastrophe of paraplegia from it is still recorded with disappointing regularity. Nor have I had any remarkable results with the numerous muscle relaxants. It seems to me a little harsh to use a drug with such widespread physiological effects to control muscle spasm which is itself so often secondary to another and primary disorder. Such drugs are known to produce undesirable side effects also. Some of these are minor but some of them are very serious. I do believe in the use of barbiturates, however, for these drugs will relax and have an analgesic component as well. I often continue them past the acute phase to remove the edge of boredom for the now comfortable patient who is simply on enforced bedrest.

I have repeatedly mentioned obesity as a common factor in many patients with these various low back disorders. We view weight reduction (either as a prelude or concomitant with more specific treatment) as essential to the overall success of our efforts. Not only are the results of most any of the therapeutic measures enhanced, but we have seen remarkable resolution of symptoms with weight reduction alone.

The foregoing general measures may accomplish much, but usually serve mainly to set the stage for success with more specific measures. We had best relate these directly with the specific entities to which they are applied.

Congenital variations in structure are not remediable. However, the chronic symptoms which attend them, and those arising from a faulty posture, will usually respond to conservative measures. Chief among the measures employed are temporary bracing, and postural exercises. In our clinic we perforce employ plaster casts which serve first to relieve more acute symptoms and secondly to demonstrate to the patient the desired attitude for his spine. Beginning at the same time are postural exercises to strengthen the abdominal and gluteal muscles which will retain the desired posture when the cast is removed. In the milder cases the cast is not employed. Additional instruction is given to the patient on the proper attitudes for sitting, lifting and squatting. All of these points must be covered or the results of such treatment may well be fragmentary. Yet some of these patients will show persistent symptoms perhaps partially relieved by rest or support, and aggravated by activity without support.

If the original diagnosis is still sustained after long observation, spinal fusion should be seriously considered. Symptomatic degenerative joint disease of the localized variety may respond to a similar regimen. If radicular pain is present it may not. When the symptoms from the process become intractable, but are relieved to some extent by effective immobilization, then spinal fusion should again be seriously entertained in the younger individuals. The overall effect of major surgery and subsequent immobilization must govern the decision to attempt spinal fusion in the older age groups.

Since degenerative joint disease of the disseminated variety occurs most frequently in the older age group, management stands here in its fullest expression. Modification of the patient's daily activities to eliminate prolonged standing, bending, lifting and climbing may reduce the

incidence of symptoms. Local heat, massage, aspirin or even a garment designed to limit the range of spinal motion may serve to reduce the remaining symptoms to a tolerable level. Weight reduction, though still desirable, seems more refractory to this patient's efforts, even under good medical direction. While these older patients are far more tolerant of their painful infirmities than younger people, do not brush them off lightly. Genuine concern for their problems when expressed sincerely will help them more than can be measured.

Spondylolisthesis we have said may occur from several causes and produce either local, or local and radicular pain patterns. By and large we prefer conservative management which may include a change of jobs. Again we insist upon weight reduction if the patient is obese. Gross muscle laxity may be corrected by postural exercises but often these exercises aggravate the symptoms. A well fitted corset or brace has provided the most consistent relief in these cases in our experience. As has been pointed out there is no correlation between the degree of slipping, or even its presence, and symptoms. Therefore spondylolisthesis itself does not stand as an indication for surgical intervention. But symptoms which remain refractory to an adequate conservative program do stand as an indication. The actual procedure to be carried out is always controversial and may not be determined until the time of operation. My own views are those proposed by Mr. Phillip Newman of the Middlesex Hospital, London, England. He suggests that in the younger age groups with both back and leg pain that the emerging spinal nerves be decompressed and the spine fused. If back symptoms only are present, fuse the spine. In the older patients with leg symptoms, decompress the spinal nerves but treat the spine conservatively. I shall not here enter the controversy regarding removal of the loosened posterior neural arch.

We have considered briefly some of the entities which account for a large segment of low backaches, apart from those covered by the other members of this panel. We have outlined an approach to their management. But we would be remiss if we did not concede that many cases simply do not respond to these measures. In some of these patients there may be psychogenic factors. Often there is other historical or physical evidence to suggest it. I am never reluctant to secure the opinion of a competent psychiatrist of my own acquaintance. But before I am willing to relegate the patient to the category of psychogenic backache I would follow him for a long, long time. Every diagnostic tool at medicine's disposal should be utilized, for I have seen organic disorders which remained obscure, yet when finally uncovered and treated, resulted in excellent recovery. Sometimes such lesions are so common as a herniated nucleus polposus, or so bizarre as osteoid osteoma, or sickle cell anemia with infarctions in vertebral bone or a Leriche's syndrome.

The low back is a complex area with very limited modes of expressing to us what disorders may be present there. Persistence to the point of a reasonable diagnosis which can be sustained is quite essential if these entities are to be dealt with effectively.

Thymic Cyst in the Neck: Case Report

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THE PURPOSE OF THIS PAPER is to present a case in which a mass in the neck was found to be a thymic cyst. There have been two previous cases of thymic cysts in the neck reported in the American medical literature. Hyde, Sellers, and Owen[5] reported the first case of a unilateral thymic cyst in the neck in 1944. This occurred in a five-year-old white male, had been in evidence eight months, and was located on the right side of the neck. This cyst contained thick yellowish fluid which was rich in cholesterin crystals.

In 1951 Weller, Pearce, and Rapoport[9] reported a thymic cyst of the neck in a four and one-half-year-old girl. This cyst occurred in the left side of the neck and was present for four months before surgical removal. The fluid in this cyst was described as cloudy and pale brown.

In addition to these two cases, King[6] in 1949 reported eight cases of "lateral lympho-epithelial cysts of the neck" which contained some thymic tissue in their walls. These eight cases apparently represented his own experience as well as cases contributed by colleagues. Four were unilocular cysts and four were multilocular. Since this was a general discussion of lateral lympho-epithelial cysts of the neck, there was no detailed information as to the contents and appearance of these particular cysts or as to the ages of the patients in whom these cysts occurred. References suggest that the "branchial cyst" with thymic-appearing tissue mentioned by Heinz[4] in 1950 is included in King's report.

Although the above-mentioned cases represent all of the reported cases of thymic cysts in the neck that we can find, there are other reports concerning thymic tissue in the neck which are well worth mentioning. Laage-Hellman[7] reported a case in which a tumor in the neck of a 26-year-old man since birth was made up of thymic tissue. He cited still another case reported by Wadon in which aberrant thymic tissue in the trachea of a 58-year-old woman was malignant and led to asphyxiation. Because of this, Laage-Hellman states that heterotopic thymic tissue must be considered potentially malignant.

This appears to be further substantiated by Pirkey[8] who reported a case of epithelioma which occurred in an "undescended thymus" in the left neck of an 11-year-old female. These two cases suggest that no age is exempt from the possibility of malignant change in cervical thymic tissue. Although these lesions have not been cysts, there is no reason why similar tumors might not arise in the thymic tissue in the wall of thymic cysts in the neck.

DEVELOPMENT OF THE THYMUS GLAND

Normally, according to Arey,[1] the thymus is derived from the third lateral pharyngeal pouches, each side contributing about equally. At about the sixth week, there develops a ventral sacculation from each of the third lateral pharyngeal pouches; this separates from the pharyngeal pouches in about one week and becomes a hollow organ, the thymic primordia. These become solid soon and about the eighth week the lower ends of the masses from right and left sides unite. It retains some separation into a right and left lobe even after its descent down into its normal position in the mediastinum.

At times the upper ends of the thymus persist higher in the neck instead of vanishing about the eighth week as is normally expected. If this

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Figure 1. P-A roentgenogram of the chest showing the cystic mass in the neck with apparent extension down into the right upper mediastinum, and resultant widening of the upper mediastinal shadow. This widening was not present on a post-operative film.

happens, they may separate from the larger lower ends and remain up in the neck as accessory or aberrant thymic tissue.

Gilmour,[3] in an excellent discussion of developmental abnormalities of the thymus and parathyroids, presented 13 cases in which thymic tissue was in unusual positions. In these cases, thymic tissue often occurred in the neck in relation with the internal and common carotid arteries. It is of interest that he found thymic tissue inside the thyroid in seven cases.

CASE REPORT

A 6-year-old colored male was admitted August 3, 1954, and discharged August 18, 1954.

Chief Complaint: Swelling on right side of neck, three years duration.

Present Illness: The child had a swelling in the right side of the neck along the anterior border of the sternomastoid muscle present since about the age of three years when it was first noted following a bout of poliomyelitis. It had existed without symptoms until about six weeks prior to admission to the hospital, and was noticed by the parents only when he laughed or cried. About six weeks prior to admission, the mass began to enlarge and continued to enlarge until the time of admission. It had been painful on palpation for the first time during that six weeks. It had not interfered with eating or swallowing. There had been no fever.

Physical Examination: B.P. 130/70. Pulse and heart rate 92 per minute. Respirations 28 per minute. Temperature 37.7° C. (Rectal).

There was a cystic mass in the right side of the neck lateral to the thyroid gland. This mass appeared to be well demarcated from the adjacent structures and was freely movable. The cyst was estimated to be four to five centimeters in diameter and was moderately tender to palpation. It extended laterally to the anterior border of the right sternomastoid muscle. It did not move when the patient swallowed.

Laboratory and X-rays: CBC, urinalysis, and serologic test for syphilis were normal. The P-A roentgenogram of the chest on 8-4-54 showed the mass in the right neck and it was suggested that there might be extension of the cyst into the thorax along the superior mediastinum (Figure 1).

Operation: Operation was carried out on 8/9/54 under general anesthesia. Incision was made over the cystic structure extending over the right sternomastoid muscle. The sternomastoid was retracted and the strap muscles divided in the direction of their fibers. It was necessary to carry this muscle-splitting cephalad in order to free the superior portion of the cyst, which extended above the superior thyroid vessels. The cyst was then removed by blunt and sharp dissection. The superior portion of the cyst was freed with some difficulty and further dissection posteriorly and inferiorly showed the cyst to be separate from the thyroid gland. Dissection inferiorly showed the cyst to extend into the superior mediastinum. In the course of the dissection, tension was placed on the cyst and it ruptured, yielding a thick, brown-red fluid. At this time it was noted that the surrounding tissue had the appearance of thymic tissue. It was felt that the inferior portion of this cyst was completely excised from the thymus, but this could not be said with certainty because of its extension down into the mediastinum. The postoperative course was uneventful and follow-up examination on 9/23/54 showed no recurrence or other abnormal features.

Gross Description: This specimen was submitted to the Pathology Department as three pieces of tissue, each of the two larger pieces measuring 3.5 by 3.0 by 2.0 cm. and the smaller measuring 3.0 by 2.5 by 1.8 cm. It was obvious that these represented the wall of a multiloculated cystic structure. The cyst lining was smooth and gray and there was a small amount of soft yellow-brown material within the cyst in places. The cyst wall varied from 0.1 to 0.9 cm. in thickness. Most of the tissue surrounding the cyst was moderately soft brown-red tissue. (As previously mentioned, the fluid content of the cyst observed during surgery was thick and brown-red in color.)

Histologic Description: The lining of this cyst was indistinct in many places but in some areas the lining appeared to be a thin atrophic layer of epithelium which was partially necrotic, but was similar in some places to stratified squamous epithelium (Figure 2). In some regions of the cyst lining there were accumulations of necrotic tissue with small slits with the appearance of cholesterol clefts. Fibrosis was prominent and within the wall of the cyst were diffuse and focal in-

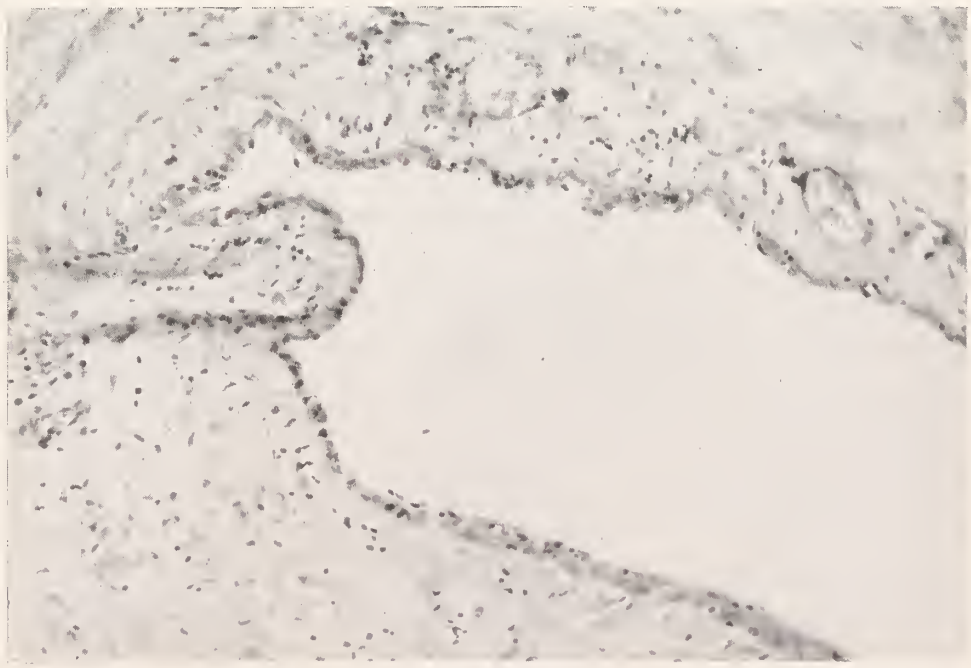

Figure 2. Portion of cyst lining showing thin, apparently epithelial lining of varying thickness. Fibrous tissue and inflammatory cell infiltrate are seen in wall of cyst. (X170)

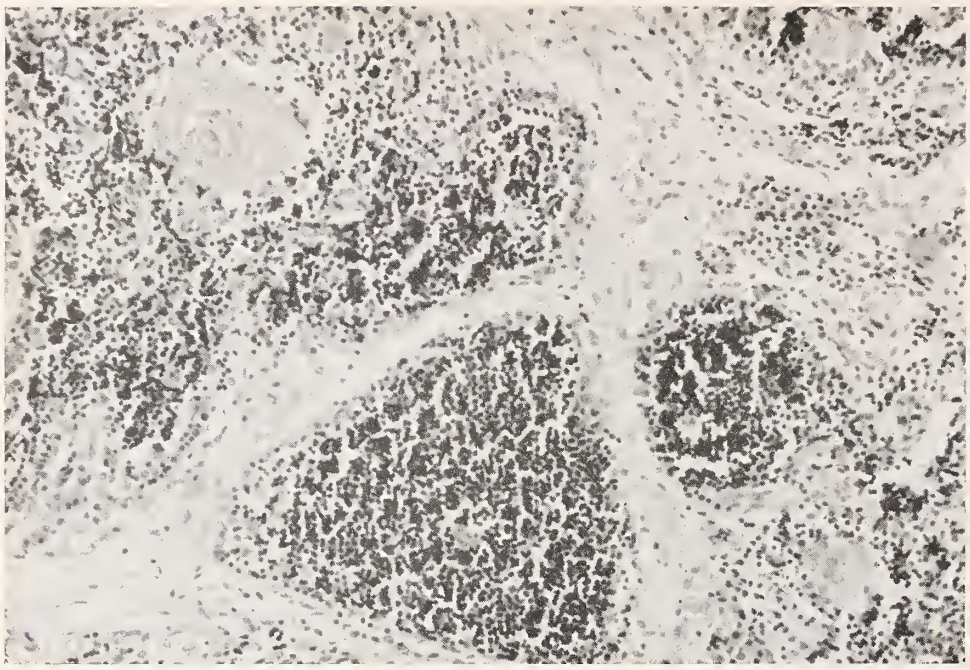

Figure 3. Thymic tissue in wall of cyst showing typical lobulation and Hassall's corpuscles (upper left). Giant cells are seen in both upper right corner and lower right corner. (X170)

filtrations of lymphocytes, plasma cells and in some areas foreign-body giant cells. In all sections of the wall examined, thymic tissue with the characteristic thymic lobulation and Hassall's corpuscles was present (Figure 3). In general, the picture was that of a cyst within thymic tissue, with evidence of chronic inflammation and resultant fibrosis in its wall.

DISCUSSION

No doubt thymic cysts occur in the neck more frequently than is apparent from our review of the literature. This is suggested by the fact that over a period of years King[6] was able to accumulate eight such cases. There are certain aspects of the thymic cyst in the neck which justify some special attention to the entity.

The wisdom of including a routine P-A roentgenogram of the chest in the workup of cystic lesions in the neck is further substantiated by the case presented. It was mentioned that the roentgenologist was able to predict from the appearance of the chest x-ray in this case that the cyst extended down into the mediastinum. This seems important whether the cyst be located laterally or in the midline in the neck. It is extremely helpful to the surgeon to have this information preoperatively.

Arnheim and Gemson[2] reported a case of "persistent cervical thymus gland" which was subjected to thymectomy, followed by a pneumothorax with fifty per cent collapse of the left lung. This occurred in a nine-month-old boy and was located in the lower neck in the midline. This infant had choking after feeding, which required operative intervention. This operation required entrance into the mediastinum which in turn resulted in a pneumothorax. Since this complication can be extremely serious and even fatal, great care must be exerted to prevent its occurrence.

On the basis of the case presented and literature reviewed it appears that the possibility of malignancy of thymic tissue should be no small consideration in lesions of the type under discussion. Two cases of malignancy in aberrant thymus tissue were reviewed, one of which was in an eleven-year-old child and the other in a 58-year-old adult. That in the child was located in the neck.

Since thymic cysts in the neck appear to occur almost exclusively unilaterally, the danger of removing parathyroids along with thymic tissue in the neck does not seem to merit serious consideration, as it is unlikely that any serious results will follow removal of perhaps only one parathyroid from one side. Nevertheless, it should be remembered that this is a possibility and it behooves the pathologist to make a thorough study of the specimen in order that he may pass on accurate information to the surgeon.

SUMMARY

The literature concerning thymic cysts in the neck is reviewed, along with other literature concerning aberrant thymic tissue which appears to have a direct bearing on the subject. A case of a

thymic cyst in the neck of a six-year-old boy is presented in some detail. The pertinent practical aspects of this case from a surgical standpoint are discussed.

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SPUTUM TEST HELPS FIND LUNG CANCER

The laboratory examination of sputum frequently can give an early indication of lung cancer, two Albany, N. Y., doctors assert.

While the test cannot always establish a definite diagnosis, it can indicate the need for further study with other more specialized techniques, Drs. Doris S. Rome and Kenneth B. Olson of Albany Medical College said in the May 11 Journal of the American Medical Association.

They pointed out that cough and expectoration are common in adults as a result of chronic irritation due to smoking, chronic bronchitis, or acute pulmonary infection.

Such persons should have their sputum examined for cancer cells in an effort to make an earlier diagnosis of lung cancer—if it is present—and thereby begin treatment sooner, the doctors said.

The doctors examined 3,102 specimens of sputum and bronchial aspirates (material drawn from the lungs themselves) from 1,203 patients in order to detect possible cancer cells. Of these patients, 266 were ultimately believed to have lung cancer. Almost three-fourths of the 266 patients had suspicious or positive results on first examination of sputum or bronchial aspirates.

It was possible to establish diagnosis somewhat more accurately with the easily obtained sputum specimens than with bronchial aspirates, they said.

Hemoptysis Masquerading as Epistaxis: A Report of Two Cases

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ALTHOUGH either epistaxis or hemoptysis can cause bleeding from both the nose and from the throat, it is unusual to encounter bleeding from the tracheobronchial tree which emerges only through the nose simulating epistaxis to the apparent exclusion of any other diagnosis. The following are reports of two widely-differing such cases.

REPORT OF CASES

Case 1.—A 27-year-old white male was seen in the office on September 11, 1951, stating that he bled from his nose the previous day, and that it was packed by his family physician with cessation of the bleeding. His physician felt that electrocautery of the bleeding point might be indicated and suggested an otolaryngological consultation. The patient said that he suffered from nosebleeds several times a year since childhood but that his current episode was the most severe of all. He stated that he had rheumatic fever in childhood, and that his health was not up to par in the recent past. He estimated a weight loss of 25 pounds in the previous six months.

On examination, the nasal cavities were found to be packed with petrolatum-impregnated gauze which was removed; there was much old blood and clots which were aspirated. The nasal septum was markedly deflected to the right side resulting in almost total occlusion of the nasal cavity on that side. No new blood or bleeding points were seen. The remainder of the ear, nose and throat examination was negative. Indirect laryngoscopy revealed a clean larynx and a glimpse into the upper trachea which was blood-free.

A diagnosis of epistaxis was made, and it was felt that a contributory factor was the markedly deflected nasal septum with its probable deflection of the inhaled air stream and resultant crusting. The patient was given a prescription for rutin and ascorbic acid, and because of the marked recent weight loss, a roentgenogram of the chest was ordered.

On the following morning before the report of the chest X-ray was received, the patient again presented himself at the office, this time with an active "nosebleed." He sat in the examining chair leaning forward holding a pan in his hands while fresh blood dripped from both nostrils. He occasionally coughed as the "blood dripped down into the throat." Clots and fresh blood in the nasal cavities were aspirated, but no bleeding point was found. The posterior pharyngeal wall was noted to be covered with blood. The larynx was then visualized with a mirror, and the entire area was seen to be plastered with fresh blood. As this observation was being made, the patient coughed, and fresh blood shot up from the trachea and splashed against the laryngeal mirror.

For the first time it was realized that the patient's bleeding was pulmonary in origin. The bleeding ceased spontaneously, and the patient was admitted to the hospital.

The chest roentgenogram was then viewed and found to reveal a marked enlargement of the heart to the left with prominence of the pulmonary conus area. The bronchovascular markings were accentuated bilaterally. The hemoglobin value was 9 grams percent. The erythrocyte count was 3,580,000, and the leucocyte count was 7,100. A sputum examination was negative for acid-fast bacilli. An electrocardiogram was read as being consistent with a mitral valvular lesion. Internal medicine consultation was requested, and a diagnosis was made

of rheumatic heart disease with mitral stenosis and pulmonary congestion with hemoptysis.

Because of the secondary anemia, a blood transfusion was given. After digitalization and further medical management, the patient was sent to another city where a mitral commissurotomy was performed.

It was later learned that the patient made an apparent excellent surgical recovery and returned to work; however, in January of 1953 he became decompensated and expired while under the care of another physician.

Case 2.—A 51-year-old white male was seen in the hospital emergency room on December 5, 1955, because of profuse bleeding from the nose of a duration of two hours which ceased just before reaching the hospital. He said that the blood seemed to run back into his throat causing occasional coughing and gagging. He stated that until the current episode he had not had a severe nosebleed since childhood. He admitted that he frequently picked crusts from his nose with resultant minor nosebleeds. He smoked one or two packages of cigarettes a day.

On examination, both sides of the nasal cavity were found to be filled with old blood and clots which were removed. The nasal septum contained two crusting perforations anteriorly, both of which were within reach of a finger inserted into the nares. No active bleeding point was seen. A coat of old blood was adhering to the posterior pharyngeal wall. A diagnosis of epistaxis was made, and it was assumed that the source of the bleeding was the crusting septal perforations for which a topical ointment was prescribed. It was felt that the etiology of the septal perforations was habitual picking of the nose.

The patient telephoned the office on December 20 and December 28, 1955, and stated that except for one slight episode of nasal bleeding, he felt that he was entirely well.

The patient was next seen in the emergency room of the hospital on January 28, 1956, because of a severe nosebleed of a three-hour duration similar to that of the previous month. He stated that since his last telephone call the previous month, he suffered a "chest cold" for which another physician administered several penicillin shots with apparent recovery. The infection was accompanied by several minor nosebleeds which the patient said seemed to drop blood back into his throat and cause coughing.

The patient was leaning forward in the examining chair with a pan held in his lap. Long clots hung from each nostril, and fresh blood dripped from their ends into the pan. The patient coughed at short intervals and complained that the blood dripped down into his throat choking him. The nasal cavities were cleaned, but no bleeding point was found. Indirect laryngoscopy revealed a hypopharynx, larynx and trachea plastered with old and fresh blood.

A diagnosis of hemoptysis was made, and the patient was admitted to the hospital at which time the bleeding ceased spontaneously. A roentgenogram of the chest revealed an area of radiodensity in the postero-superior segment of the right lower lobe. The hemoglobin determination was 12 grams. The erythrocyte count was 4,000,000, and the leukocyte count was 9,000.

A tentative diagnosis was made of bronchial tumor or bronchiectasis, and the patient was seen in consultation by a thoracic surgeon. Bronchoscopy revealed a tumor in the posterior branch of the right lower lobe bronchus, a biopsy of which was diagnosed microscopically as an epidermoid carcinoma. A right radical pneumonectomy was performed, and the patient's recovery was uneventful. At last report he was working and feeling well.

COMMENT

It is distressing to consider that despite an adequate history and examination under the circumstances, the diagnosis of hemoptysis was initially not even entertained in either case. Fortunately, both patients were examined later during an active bleeding episode, or the true diagnosis might have been even further delayed. In the light of the gravity of the primary conditions involved, promptness of diagnosis was certainly desirable.

It is of interest to note that the diagnosis was further complicated in both cases by nasal conditions which offered readily-apparent sources of bleeding but which were entirely innocent of blame.

In retrospect, it is observed that both patients possessed a deeper-than-average nasopharyngeal space. This anatomical variation would facilitate the discharge of blood expelled with sudden force from the trachea directly into the posterior choanae without filling the oral cavity with blood.

Thus, such a patient leaning forward would present a picture of epistaxis as pulmonary blood was expelled from his nose. Any blood present in the throat or an associated cough might be blamed on the usual dropping of blood from the posterior nose into the throat.

SUMMARY

Hemoptysis is to be considered when the apparent diagnosis is epistaxis but no specific bleeding source is found in the nose. Indirect laryngoscopy is a diagnostic aid in such cases. Two cases are reported and briefly discussed.

DOCTORS SUGGEST POSSIBLE CAUSE OF SARCOIDOSIS

Researchers have found some evidence as to the cause of an unexplained disease by studying changes in the disease symptoms during pregnancy.

The doctors made their report on sarcoidosis and pregnancy in the May 11 Journal of the American Medical Association.

Sarcoidosis is a chronic infectious disease of unknown cause, which produces tumor-like lesions in the skin, lymph nodes, salivary glands, eyes, lungs, bones, and nearly every other part of the body.

The doctors studied 10 patients with the disease as they went through 16 pregnancies over a period of eight years at the Hospital of the University of Pennsylvania, Philadelphia.

Two facts noted in the study led them to suggest that sarcoidosis may be a "disease of hypersensitivity" like rheumatoid arthritis, hay fever, and several other illnesses: (1) although sarcoidosis has been thought to be caused by tuberculosis, pregnancy affects the two diseases differently, and (2) the same drugs as those used in hypersensitivity seemed helpful to women with sarcoidosis.

The doctors found generally that pregnancy had a "beneficial effect on sarcoidosis that is frequently lost after delivery." Improvement occurred in eight of the 10 patients during pregnancy: in two there was no change. Except for the development of skin lesions of the leg in one patient, no worsening of the disease during pregnancy was noted. Relapse frequently occurred after delivery and four patients developed new symptoms immediately after delivery.

Tuberculosis is still considered as a possible cause of sarcoidosis, but other studies have shown that tuberculosis does not improve and is probably aggravated during pregnancy. The improvement in sarcoidosis during pregnancy would rule out tuberculosis as a cause unless the "ancient argument" of the presence of a "different" kind of tuberculosis is used, the authors said.

However, improvement during pregnancy with subsequent relapse after delivery has been reported in diseases of hypersensitivity, such as hay fever, asthma, psoriasis, fibrositis, and rheumatoid arthritis. In addition, sarcoidosis is frequently associated with bodily changes which also occur in diseases of hypersensitivity.

Treatment with synthetic adrenal hormones, which has been successful in the hypersensitivity diseases, also improves sarcoidosis, they said. The improvement during pregnancy may be due to an increase in adrenal hormone production during pregnancy.

Since pregnancy does not exert a harmful effect on sarcoidosis, termination of the pregnancy is rarely necessary, the authors said. However, the possible harmful effects of sarcoidosis on pregnancy need more study. Among the 16 pregnancies there were two miscarriages and three congenital abnormalities in the infants.

The authors are Drs. Robert L. Mayock and Roy R. Greening, Hospital of the University of Pennsylvania; Dr. Robert D. Sullivan, Veterans Administration Hospital, New York, and Dr. Ralph Jones Jr., Jackson Memorial Hospital, Miami, Fla.

The Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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WHAT TO DO AFTER THE DOCTOR ARRIVES

A LAW PASSED by the recent legislature, requiring the chemical name of poisonous elements to be listed on the label of all toxic household products, will do much to aid the doctor who is called to treat a patient suffering from the wrongful application of a chemical which was formerly designated by a mysterious and uninforming trade name.

The number of household products which may be harmful if ingested or wrongly used is increasing rapidly. Many of the newer products contain organic compounds which were unknown a few years ago. The toxicology of these new poisons often is not known to the physician.

When the doctor is called to treat a person who is ill as a result of a household poison the mystery is compounded by the fact that almost all the preparations are marketed under a trade name which does not indicate the actual poison.

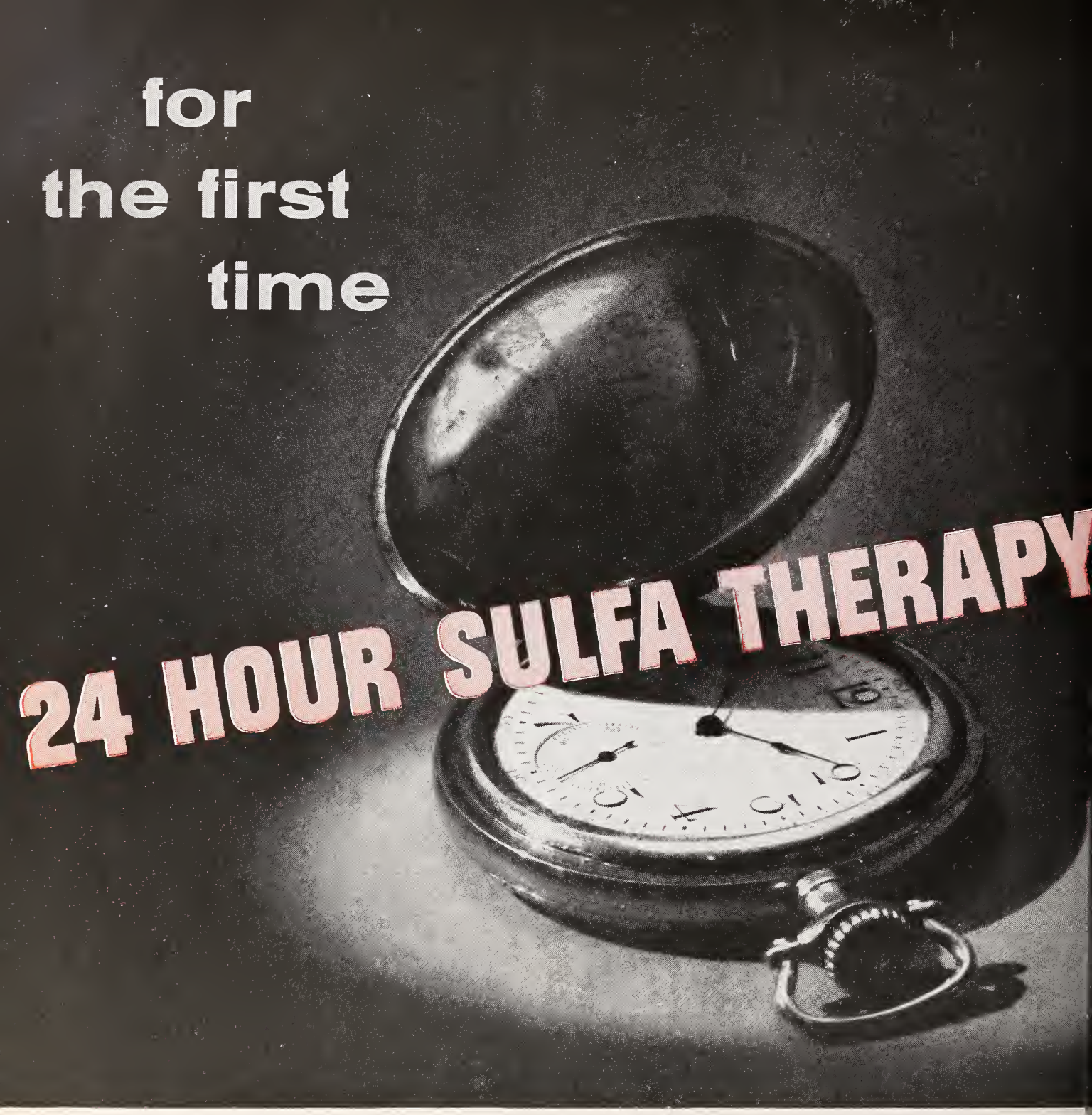
A partial solution to the problem has been provided by Poison Information Centers. Many large cities now possess such centers, located usually at a hospital or at the Board of Health. Up-to-date information of all the toxic preparations is kept on file and may be relayed to physicians in emergency or other situations. Each county of our state should have at least one such center.

Another factor of life-saving importance has been provided by a law passed by the 1957 General Assembly, requiring that the chemical name of the poisonous ingredient be placed on the label of all poisonous household products.

In addition to the label specifications, the law requires that each such product be registered with the State Board of Health, and that this registration be changed in case the trade name or the manufacturer is changed.

The law was suggested by the Indiana State Board of Health and had the enthusiastic support of the Indiana State Medical Association. It goes farther than the Federal Law, in that it covers all household products, and is applicable to products produced and sold within the state. It is probably the first state law of its kind.

Continued



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1. Boger, W. P.; Strickland, C. S.; and Gylfe, J. M.: Antibiot. Med. & Clin. Ther. 3:378 (Nov.) 1956.

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Toxic preparations sold for use by farmers or for industrial use are exempted from the provisions of the bill, since agricultural pesticides are used in the open and are less likely to cause poisoning, and because industrial plants maintain careful supervision of dangerous chemicals and have the necessary treatment information on hand.

There is no more frustrating experience for a physician than to be confronted with a seriously ill victim of accidental poisoning, and not be able to ascertain the specific agent involved. The label law and the information which may be obtained from the State Board of Health or from the nearest Poison Information Center will do much to remedy this situation, and will save many a life.

FRENCH LICK IN OCTOBER

THE ANNUAL CONVENTION will be a little earlier than usual this year. Sunday, October 6, will see the business part of the meeting under way at French Lick. The scientific sessions are scheduled for Monday, Tuesday and Wednesday, October 7 to 9.

The medical program has been settled on a firm basis, and at this writing awaits only a few acceptances to be complete. It has been arranged on a new schedule and promises to be valuable and of general interest. The convention entertainment and the recreational features of French Lick will be equally attractive. Now is the time to mark off October 6 to 9 on the office calendar, and if not already attended to, better write the French Lick-Sheraton Hotel for reservations.

Four general scientific meetings are planned, one each on Monday afternoon, Tuesday morning, Tuesday afternoon and Wednesday morning. These sessions will be devoted to subjects of general interest and will be addressed by authoritative clinicians.

Atherosclerosis, coronary disease, benign lesions of the colon, cryptorchidism, office gynecology, toxemias of pregnancy and infant resuscitation will be discussed. Papers will be read on disability rating, work classification of the cardiac, and on an ear, nose and throat subject of interest for general practitioners.

The six clinical sections of the association are not planning scientific programs, but will meet for short business sessions, possibly at lunch time.

The ever popular instructional courses will be held on Monday and Tuesday mornings. Monday morning is also set aside for golf and trap shooting.

The smoker and stag party will be in the early part of Monday night and later that evening a special entertainment will be provided in the main dining room for physicians, wives and guests. President's Night will be celebrated on Tuesday night and the Annual Dinner will climax the convention on Wednesday night.

Advance notices for the technical and scientific exhibits indicate that they will be bigger and better. Time is allowed in the scientific program for an "exhibit break", so that the exhibitors may be well patronized.

As in the past, as much as possible of the business of the convention will be transacted at times not interfering with the scientific part of the program. Preliminary sessions of the Executive Committee, the Council, and the House of Delegates will convene on Sunday afternoon. Reference committee hearings will be held on Monday morning, and the final meeting of the delegates will be on Wednesday afternoon, starting with lunch, and followed by meetings of the Council and Executive Committee.

A reception for members of the Fifty-Year Club will be held in the Blue Room at 5:30 on Wednesday afternoon.

WORLD MEDICAL ASSOCIATION SPEAKS OUT

THE WORLD MEDICAL ASSOCIATION is an organization composed of the representative medical associations (such as the A. M. A. in the United States) of many of the countries of the world. It is comparable to the A. M. A., but is on an international basis. It represents predominately the opinions, ethics and ideals of the physician in private practice.

The World Health Organization is an agency which was organized by the United Nations. Its representatives and delegates are chosen by the governments of the participating countries. In the case of nations with socialistic medical systems the representatives, no doubt, view medical problems and their solution from a socialistic point of view.

Although practically the same group of countries send representatives to both organizations, the World Medical Association has been characterized by policies and opinions which are in accord with the free practice of medicine, and are at least less socialistic than those of the World Health Organization. This is due possibly to the fact that the W. M. A. represents practicing physicians and not governments. The fact that the A. M. A. has taken an active interest in the W. M. A., and has been instrumental in formulating its policies, has also tended to mold its character in conformity to the American system of medicine.

One of the topics for discussion at a recent Assembly of the W. H. O. in Geneva, Switzerland, was "The Role of the Hospital in the Public Health Programme".

A delegation from the W. M. A. attended this meeting and presented the W. M. A. thought on this subject in a document which stressed the following points:

1. Health care is an undertaking requiring a team approach—the team to be composed of doctors, dentists and their ancillary personnel as well as certain agencies such as professional organizations, voluntary and official health agencies, social welfare agencies and government.

2. The prime consideration in the whole program is, or should be, the public.

3. The general practitioner is the doctor best qualified to offer continuity of health care. He should have free access to the hospital to continue the patient's health care and to provide him with the opportunities of continuing medical education provided through hospital meetings and research.

4. A hospital is an institution and cannot replace an individual or group of individuals without medical care becoming depersonalized and mechanical.

5. The hospital achieves and holds its reputation almost exclusively by virtue of the reputation of its staff.

6. Hospitals cannot function without doctors. Doctors cannot practice modern scientific medicine without hospitals. One of the first questions to be answered is: Who is to determine how medicine is to be practiced both in hospitals and elsewhere?

7. The moment that full reliance for individual and family responsibility is placed on government an essential element in "mental and social well-being" is undermined.

The title of this document was "The Practicing Doctor's Evaluation of the Role of the Hospital in the Public Health Program".

The result of this discussion will be interesting. If and when it is available The JOURNAL will be interested in publishing the report.

Trade magazines report that $32 million was spent during 1956 on television spots for drug products. This included $6 million to advertise cold remedies, $4 million for headache remedies, and $7 million for indigestion remedies.

Guest Editorial:

MANAGEMENT OF THE DIABETIC PATIENT—A NEW LOOK

THE OPENING, by Diabetes Foundation, Incorporated, of the Hospital Teaching Clinic associated with the New England Deaconess Hospital marks a new effort in the prevention of the disastrous complications of diabetes in the arteries, kidneys and eyes. The purpose of the Clinic with its 40 beds, devoted largely but by no means entirely to younger diabetic patients early in the course of their disease, is to teach them how to control diabetes with the use of insulin, diet and the various aids employed in the treatment and prevention of complications. The need for a new and more vigorous attack on these complications has been recognized for many years in all parts of the world where diabetes has become increasingly frequent and where the increasing duration of the disease gives a longer period for the development of complications if treatment has been delayed, inadequate or interrupted.

Diabetes Foundation, Incorporated, which sponsors and owns the new building housing the Clinic, is an organization established under Massachusetts law as a charitable and educational society for the study of diabetes and the teaching to patients, physicians and nurses of the fundamental facts about diabetes. The Foundation sponsors a research laboratory, and in the new building an entire floor has been provided for extensive research programs in diabetes to be carried out with the co-operation of Harvard Medical School. The Foundation further supports two camps for diabetic children at Oxford and Charlton, Massachusetts, where between 350 and 400 diabetic children have periods of two to four weeks each in a laboratory-equipped outdoor camp, under the protection of physicians and nurses.

On the ground floor and the first floor of the building, which may be considered as a living memorial to the very active president of the Foundation, Dr. Elliott P. Joslin, members of the Joslin Clinic have their offices and clinical laboratory on a rental basis.

The floor for patients is staffed and administered by the New England Deaconess Hospital, located directly across the street from the Teaching Clinic. Since all patients will be ambulant and no severely complicated cases will be accepted in the Teaching Clinic, many of the expensive features of hospital equipment will be unnecessary. It is expected that a material reduction in the cost of rooms, food and hospital care will thus be accomplished. If patients will co-operate by helping the nurses in the care of rooms and going to the cafeteria for food rather than being served in their rooms, a new type of economy in medical care may be established.

The building of the Hospital Teaching Clinic was made possible by 7000 gifts to Diabetes Foundation, Incorporated. These gifts ranged from dollar bills to the largest single gift of $271,000.

—*The New England Journal of Medicine*

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SEARLE

The President's Page

COMMITTEES AND COMMITTEE WORK

DID YOU EVER STOP TO THINK of the importance to our great organization of having functioning committees, committees that meet with a definite purpose, explore the problems in their field, and get things done? The best committees usually are not one-man affairs, but are often sparked by the vision and incentive of one man into a course of action that culminates in results.

The Indiana State Medical Association in general has been very fortunate in the selection and functioning of the several committees which account for most of the constructive work done in our organization. We are presently engaged in the task of streamlining our entire committee structure with the idea of modernizing and rendering more effective our necessary committee work. In the past, it has been our observation that while it was very easy to start a new committee, when its work and usefulness had largely expired it was very hard to eliminate it. This builds up an unwieldy committee structure that tends to be self-perpetuating, and not always in the best interests of the medical association.

We have tried not to make our requests on the physicians of the state of Indiana this year too numerous or burdensome, but are now going to ask three things of the general membership:

1) Will you not volunteer for service in fields in which you are especially interested? This will be of assistance to your incoming officers when making up their lists.

2) Please let us have your suggestions as to committee work and what we should be doing or perhaps doing better.

3) If you have suggestions as to what changes in the committee structure may be made, please contact Dr. Wm. C. Reed of Bloomington, chairman of the committee, Dr. M. C. Topping, President-Elect, or me. Your suggestions will be given full consideration.

We are now engaged in the selection of reference committees for the annual session. These appointments, particularly of the chairmen, call for selection of physicians with judicial aptitude, who can approach the problems at hand with open mind and arrive at a feasible and reasonable conclusion in their report to the House of Delegates.

In conclusion, and in case credit has not been given previously, I should like to acknowledge the full-scale cooperation and functioning of the committees this year. I am very appreciative of their unselfish labors and devotion, the results of which may well be of lasting benefit in many cases. Thank you, one and all.

Elton R. Clarke, M.D.

The Woman's Auxiliary

REPORTS TO I.S.M.A.

Dear Doctor:

This report contains the first cheeps from the egg. It is a little hard to say this is the end—or this is the beginning—because the work of the Auxiliary is to carry on without interruption the wishes of the Medical Association from year to year. Only our personnel changes somewhat.

This year our morale has received a distinct boost by financial aid from the State Medical Association, for which we are very grateful. A portion of these funds was used for a most delightful and instructive House of Delegates Meeting in Richmond in April. A part has been designated for increasing our membership.

New ideas are being brought forth by the AMEF Committee for your consideration. The committee on Medical Care Insurance is studying a plan designed to boost *your* Blue Shield Plan. An extra page is being added to The Hoosier Doctor's Wife so that the county Auxiliary news may all be printed for better exchange of ideas. Our Safety Committee chairman's name is to be submitted for the Carol Lane Award.

More details will be reported to you on this page in the future by the chairmen of these committees.

AREA MEETINGS

Help your wife make arrangements to attend the following meetings to be held in four areas with several districts participating in each meeting:

I. Districts 1, 2 and 3—French Lick-Sheraton Hotel, June 17, 10 a.m.
Mrs. Wendell Stover, Boonville.

II. Districts 4, 6 and 7—Batesville Country Club, June 18, 10 a.m.
Vice-president—Mrs. Kenneth Hill, 100 Leland, New Castle.

III. Districts 8, 11, 12 and 13—Tippecanoe Country Club, Tippecanoe Lake, Leesburg, June 25, 10 a.m.
Vice-president—Mrs. Burton Kintner, 3520 East Jackson, Elkhart.

IV. Districts 5, 9 and 10—Tippecanoe Country Club, Shafer Lake, Monticello, June 24, 10 a.m.
Vice-president—Mrs. Donn Gossom, 1904 Ohio Blvd., Terre Haute.

Jean Dudding

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President, 1957-1958

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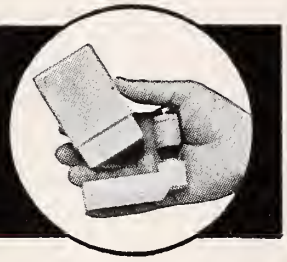

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Riker LOS ANGELES

Use of Atropine and Other Cycloplegics: Be Forewarned

THE COMMITTEE on Conservation of Vision of your State Medical Association wishes to bring before the readers of The JOURNAL the following three matters.

I. **ATROPINE, FOREIGN BODIES:** Over the nation, ophthalmologists have ceased the use of atropine or atropine ointment in corneal foreign body or abrasion cases at the time of removal of the foreign body. Hospital interns and some practitioners have continued this outdated practice. Atropine and some of its derivatives keep such a pupil dilated for ten or more days and affect the accommodation for some time unnecessarily and may keep an employed person from working. Atropine can be used later if a definite iritis should develop in such case, which is rare.

II. **CYCLOPLEGICS IN SUSPECTED IRITIS:** Both iritis and glaucoma are painful and difficult to differentiate. The two conditions can occur together. Differentiation and treatment is properly the scope of the opthalmologist, who can better gauge the proper medications, and proper length of treatment, and treat complications before and when they occur. It is no pleasure to start treating an eye that seems to be an iritis with cycloplegic and find later it has been a glaucoma eye and has been complicated by the use of atropine. Cycloplegics do not relieve eye pain in abrasions, foreign body cases, or glaucoma. Glaucoma will be discussed in a later JOURNAL issue. Watch for it.

III. The Committee of Conservation of Vision will introduce before the House of Delegates this fall a very important resolution. For medico-legal reasons doctors of medicine should not dilate pupils for optometrists or non-medical people. Medical diagnoses should not be made by optometrists. We beg of Indiana physicians to think twice before doing this service.

The resolution will be somewhat as follows:

RESOLUTION

By: Committee of Conservation of Vision, ISMA

WHEREAS, An editorial in the February 1957 issue of the Maine Medical Journal calls attention the fact that certain doctors of medicine have used cycloplegic medicine on occasions at the request of optometrists, and

WHEREAS, There are many dangers attached to such indiscriminate procedure, and

WHEREAS, since the medical-legal aspect involves the doctor of medicine only,

NOW THEREFORE BE IT RESOLVED, That a copy of this Maine Medical Journal editorial be spread on the minutes of the Indiana State Medical Association and printed in The JOURNAL of the Indiana State Medical Association.

W. B. Matthew, M.D., *Chairman*
J. V. Cassady, M.D.
Donald I. Dean, M.D.
E. O. Alvis, M.D.
Joseph L. Larmore, M.D.

CYCLOPLEGIA AND THE OPTOMETRIST

A Question of Malpractice for the M.D.

It has been brought to our attention that occasionally practicing physicians have been asked to administer cycloplegic medicine for optometrists so that the optometrist may then refract (fit glasses) to children and complicated refraction cases. It is also noted that certain physicians do not know that optometrists are not medically trained and not legally allowed to use or prescribe medicine in any form. They are not doctors of medicine and only use the title of doctor because of state legislative action. Although this has hap-

pened in only a few isolated instances, the dangers involved are considerable.

First, there are cases in which use of a cycloplegic may be disastrous; namely, in cases of glaucoma in which the patient might become blind. This is especially true of the narrow angle acute type of glaucoma in patients who may never have had a previous attack. This type of eye condition can only be safely recognized by a well trained ophthalmologist.

Secondly, malpractice suits against the optometrist would not apply, as he is not a doctor and did not prescribe the drug. The doctor of medicine would bear the brunt of the legal action and rightly so.

Optometrists are not trained to the degree that they can judge the type of case needing cycloplegia and the great majority of them realize this and do not compromise a friendly physician in this way.

WHAT "TODAY'S HEALTH" SAYS ABOUT BREAD

"Enriched bread," says Today's Health, publication of the American Medical Association, "deserves a prominent place in reducing diets. It is highly nutritious. It provides protein of excellent quality applicable for all protein needs, growth as well as maintenance of body tissues; the B vitamins, thiamine, niacin, and riboflavin; and the minerals iron, calcium, and phosphorus. Enriched bread furnishes needed energy, but contrary to popular belief it is not fattening. One average slice provides only 63 calories. The weight-reduction diet may include one to six slices per day, depending on the daily allowance of calories. Enriched bread is universally liked; therefore it lessens the hardship of dieting. It blends well with other foods. It affords eating pleasure and a sense of satisfaction, and the cost of enriched bread continues to be notably low."

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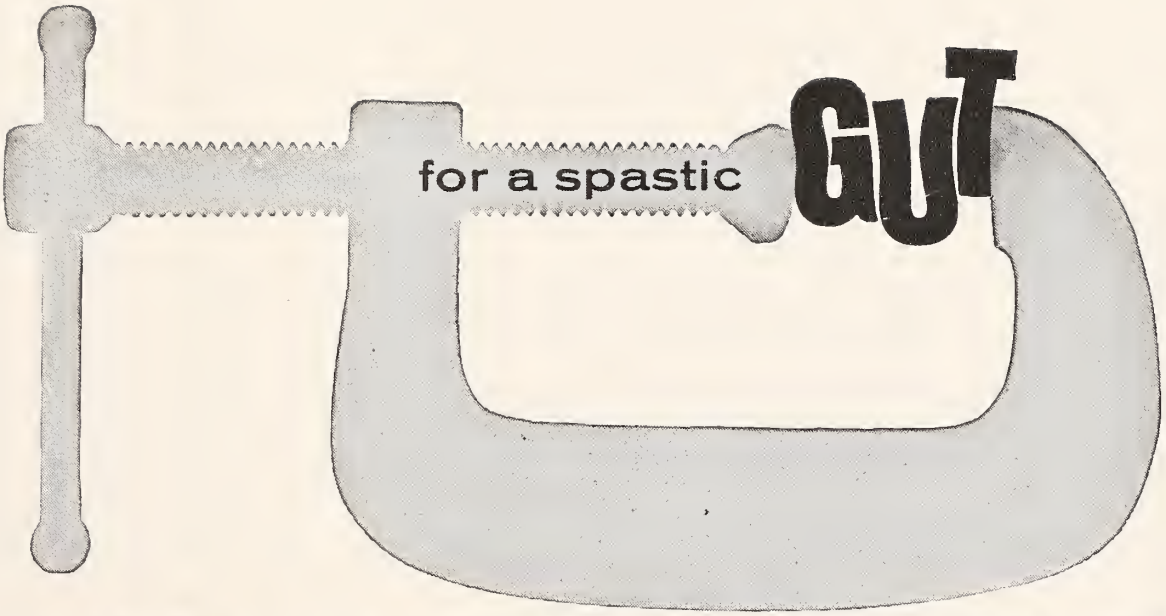

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As the year ends let us take time to consider carefully what it has brought to us, or better still, what we have brought to it.

Report of Woman's Auxiliary President to House of Delegates in Richmond

MRS. WILLIAM R. TINDALL*

Shelbyville

THE WOMAN'S AUXILIARY to the Indiana State Medical Association will complete its twenty-ninth successful year at this, our thirteenth annual House of Delegates meeting.

Through the cooperation of the state officers, state committee chairmen, county presidents, and each individual member, Indiana has made an enviable record. Again, our Auxiliary has gone forward.

Today we will listen to the reports of officers, committee chairmen and county presidents, and from these we can gather our outstanding Auxiliary story. It has been a pleasure to know better those whose efforts reflect the purpose of our organization.

This has been a tremendously busy year, yet most rewarding. Your President did not keep even a rough estimate of the miles traveled either by car or air, but the figure would be a large one.

On the National level, your President represented Indiana at the Presidents' Conference in Chicago last October, and participated on the Safety Panel, a new field of activity this year.

Your President attended the Rural Health Conference in Louisville and the Hoover Commission meeting in Indianapolis.

It was her pleasure to attend the Michigan State Meeting in Detroit, and the Illinois Conference in Chicago. At the Michigan State Meeting, printed reports were given delegates, hence the innovation of the printed booklets for all of you here.

In January, at the Agricultural Conference at Purdue University, the 4-H $100 scholarship was presented to Carol Sue Kerns of Vincennes, who had done outstanding 4-H work and academic work in Vincennes High School.

On the State level: Four Area meetings were held at Clifty Falls, Spring Mill State Park, Lake Wawasee, and the Lafayette Country Club, respectively. Your President also presided at three Executive Committee meetings, three Board meetings, and the Fall Assembly.

Your President also attended eight District meetings and visited 16 County Auxiliaries, and was extremely sorry conflicts made it impossible to accept all invitations, both from District and County organizations. Your warm and gracious hospitality, and the many courtesies extended, were deeply appreciated.

The honor was accorded your President to attend the Executive Committee meeting of the Indiana State Medical Association with your Treasurer and Corresponding Secretary. After our plans were outlined to them, we had an unexpected surprise. The Executive Committee voted to give the Auxiliary $1,000 to further our work, with especial emphasis being given to our Spring and Fall meetings, AMEF, membership, and The Hoosier Doctor's Wife.

At the invitation of the AMEF chairman of the Indiana State Medical Association the Auxiliary AMEF committee attended their meeting together with your President. *Continued*

* President, the Woman's Auxiliary to the Indiana State Medical Association, 1956-1957.

In October, at the ISMA House of Delegates, your President made a detailed outline of activities of the Auxiliary, and was most hospitably received. She was accorded the privilege of writing an Auxiliary page in The JOURNAL of the Indiana State Medical Association to inform the ISMA of Auxiliary activities. The ISMA Rural Health Committee invited your President and the members of the Auxiliary committee to attend their meeting, at which time we were encouraged and urged to hold as many Health Days as possible.

To enumerate your Committee achievements would be repetitious since you will hear about them later, but I will mention some of them briefly. Our goal this year was set for 10 Health Days, and while we actually held only 8, 6 others are planned for the future. So, as a result of your interest and response, 14 Health Days will be held. This is most gratifying to your President. Again, we know that any organization is only as successful as each individual member makes it.

We are justly proud of our Today's Health record, which will also be outstanding on the National level. We had a total of 5,023 subscriptions. Marshall County had over 750% of quota; Kosciusko had over 600%; 10 counties were in the 200-500% range; and 26 counties were over 100%.

AMEF contributions will exceed $9,000; we may reach $10,000.

BULLETIN subscriptions have increased to 173.

Recruitment figures are still advancing with contributions of more than $7,000 made for loans and scholarships for nurses.

These are the more tangible reports, but the programs followed by all the other committee chairmen were commendable. I should like to mention specifically the Safety Program which was new this year. Your State Safety Chairman organized a Safety Council in her county which she will tell about at a later time.

With the addition of one new County Auxiliary—White County—Indiana has 80 counties organized into 63 Auxiliaries.

Including the 47 members-at-large, our total membership is 2,665, a gain of 139.

At this time, your President wishes to thank the ISMA for both assistance and guidance this past year. It has made us truly an Auxiliary to the men we married.

I wish to thank the ISMA headquarters and JOURNAL staffs for their help and cooperation.

My thanks to Blue Shield, too, for the many favors shown the Auxiliary.

My thanks to all of you who served on committees or were active in your own local Auxiliaries. Without your united support, Indiana could not have gone forward.

Your President wishes to express sincere thanks for your letters of commendation and confidence, and for your expressions of loyalty and friendship.

It has been a very high honor to serve as your President this last year, and the privilege of meeting and knowing you better will remain a cherished memory.

The year is closed, the record made,
The last deed done—the last word said,
The memory alone remains,
We turn to meet another year.

To the new officers, best wishes for continued success!

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Four Departments at Indiana University School of Medicine Have New Chairmen

BY RECENT ACTION of the Board of Trustees of Indiana University three members of the staff of the School of Medicine have been promoted to department chairmanships and one new appointment to a chairmanship has been announced by Dean John D. VanNuys.

Dr. John A. Campbell, acting chairman of the Department of Radiology during the last year, has been named chairman, succeeding Dr. Raymond C. Beeler, who was head of the department from 1931 until 1956.

Dr. Donald E. Bowman has been named acting chairman of the Department of Biochemistry and Pharmacology, succeeding Dr. Rolla N. Harger, who was chairman for 22 years.

Dr. Samuel H. Hopper, who has been acting head of the Department of Public Health since the death of Dr. Thurman B. Rice in 1952, has been named chairman of the department.

Appointed to fill the vacancy created by the retirement of Dr. J. O. Ritchey as chairman of the Department of Medicine, was Dr. William M. M. Kirby, who has been on the faculty of the University of Washington School of Medicine for the last eight years.

In announcing the new chairmen, sincere thanks was expressed by the I.U. Board of Trustees for the many years of service given the School of Medicine by the retiring department heads. Dr. Beeler, who has been on the staff since 1919, will continue as a Professor of Radiology; Dr. Harger, also on the staff since 1919, will remain on the faculty as Professor of Biochemistry and Pharmacology; and Dr. Ritchey will remain as Professor of Medicine.

Dr. Campbell, who received his doctor of medicine degree from the University of Cincinnati, has been a member of the faculty at the School of Medicine for 14 years, and has headed the radiology service at the university hospitals. He also directs an extensive research program. Dr. Campbell serves as a radiology consultant to several hospitals and participates in radiology meetings throughout the country. He has been a frequent contributor to several scientific publications, writing on radiation therapy and diagnosis.

Dr. Hopper received his M.S. and Ph.D. degrees from Massachusetts Institute of Technology and did graduate work at Harvard School of Public Health. Before coming to I.U. he was on faculties of Georgia Tech and the University of South Carolina. He served with the U. S. Public Health Service during World War II in charge of a sanitation program for vessels operated by the War Shipping Administration.

Dr. Bowman has been on the I.U. School of Medicine faculty since 1941 and Professor of Biochemistry for the last five years. He received his Ph.D. degree from Western Reserve University. His research projects, particularly in the field of enzymes and their role in blood coagulation and such growths as cancer, have brought him wide recognition.

Dr. Kirby has gained national recognition through his research in infectious diseases and diseases of the chest and lungs. He is a native of Springfield, South Dakota, attended Trinity College at Hartford, Connecticut, and received his M.D. degree from Cornell University Medical College. Dr. Kirby interned at New York Hospital and served his residency in internal medicine at Stanford University Hospitals. He was in military service from 1944 to 1947, was a visiting investigator for the Rockefeller Institute for Medical Research and a member of the faculty at Stanford University School of Medicine before going to the University of Washington in 1949.

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THERE'S some mighty shrewd wisdom in what Joe says. But human nature being what it is, far too many of us still seek medical advice from those who aren't qualified to give it.

No matter what's bothering you . . . constant fatigue, nerves on edge, recurring aches and pains . . . it is never wise to stay away from your doctor in the hope that you'll run into somebody who will know "just what's best" for your trouble. In fact, it's often dangerous to accept an amateur's "sure cure."

Seek a friend's advice, if you wish, on almost any other problem. But when it comes to your health, and that of your family, by all means don't let anyone other than a physician advise you.

By seeing your doctor at the first sign of trouble, you will not only avoid the hazards of amateur medical advice, but chances are you will save time and money in the long run. In fact, prompt and proper medical care may well turn out to be one of the biggest bargains ever to come your way

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Fifty Years Ago . . .

SCENE I

"PATENT MEDICINE and Quack Doctor Advertising" is the title of a lusty editorial in the 1908 volume of The JOURNAL. It has a hard right punch to the celiac plexus and, just in case any doubting Thomases might not believe what one of their own Hoosier brethren had to say, the editor quoted an editorial of equal force from the New Orleans *Morning World.*

Speaking of "Quacks and Their Agents," the New Orleans editor said: "If you had a wart on your nose and your surgeon began to remove it by soaking your feet, you would suspect him. A saloon-keeper, who sold you half the villainy contained in the bad whiskey in many of the marvelous cures of quackery the moral-wave papers take pay for aiding and selling, would be jailed for poisoning. Yet these papers are shrieking prohibition and high license in one column and selling the vilest, most fraudulent bad whiskey in another column. The only difference is that their bad whiskey is not labeled whiskey but goes under some high-sounding name and purports to cure every ill on the face of the earth. . . .

"The quack and the faker must go at the next session of the legislature. . . . Police laws prevent the selling of stale fish, and no proposition could be fishier than this class of swindle, and no means of money-getting baser than promoting such fraud. In the matter of public health the state is vitally interested. Health is humanity's highest asset. Steadily civilized government has suppressed encroachments of fakers on human ignorance and credulity and stupidity. The quack is the blatant faker who professes to be able to do more than the sad experience and exhaustive scientific study of generations has realized. . . ."

And *Collier's Weekly* of that year published a series on "The Great American Fraud," appealing to ministers and editors to wage a vigorous campaign against medical quackery.

SCENE II—FIFTY YEARS LATER

The U. S. Post Office Department says the public is spending about 50 million dollars a year for "miracle cures" promoted by quacks and that the U. S. mails are being used to promote such quackery.

Fifty million dollars is a lot of money to throw away . . . spent on research at the rate of a million a year for the last 50 years (since those earnest editorials were written) perhaps even more of the answers would have been found to ease the burdens of the ill and the aged.

— 50 —

Fifty years ago it was believed that tuberculosis could not be successfully treated in this climate. Patients were sent to various localities having different climates, temperatures and altitudes. Eventually, certain members of the medical profession concluded that proper methods of treatment could be successfully applied regardless of climatic conditions.

Accordingly, Dr. Thomas J. Beasley in 1907

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opened the Rockwood Sanitarium near Danville, Indiana, for the treatment of tuberculosis. It was the first sanitarium of its kind in Indiana and it had a capacity of 25 patients. It was operated until 1913. At that time the legislature authorized the establishment of state and county hospitals for the free treatment of tuberculosis.

This pioneering work served to demonstrate the feasibility of the treatment of tuberculosis in this climate.

— 50 —

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There was heartbreak 50 years ago, too . . . culled from those early JOURNAL pages were these lines: "I regret to make the following report of a death from chloroform anesthesia, but duty to the profession compels it. Harold D., aged almost 6 . . . the patient took the anesthetic beautifully, his breathing was even and regular at all times, his pulse was continuously steady and of good quality. Within 12 to 15 minutes from the beginning of the anesthetic, without warning, the patient ceased breathing and, do all we could, we could not resuscitate him, though his radial pulse was perceptible for nearly a minute longer. Evidently it was a clear case of paralysis of the respiratory center."

— 50 —

Fifty years ago this month as Indiana physicians prepared to go to French Lick for the state convention The JOURNAL advised them that the "fame of the springs antedates the arrival of the first white settler in the region, for, according to Indian legends, the waters were regarded by the red men from time immemorial as a sovereign remedy for most of the ills to which flesh is heir, and the springs was the mecca to which they carried their sick for hundreds of miles by many a winding trail through the primeval woods. . . ." —j.s.g.

— 50 —

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Photographs: Auxiliary Convention

Two of the many features of the Thirteenth Annual House of Delegates of the Woman's Auxiliary to the Indiana State Medical Association are pictured here. The meeting was held in Richmond with the Wayne-Union County Auxiliary acting as official host.

Photographs above were taken at the banquet April 25 and show left to right: Mrs. Frank Gastineau, AMA Auxiliary vice-president; Elton R. Clarke, M.D., ISMA president; Mrs. Robert Flanders, National Auxiliary president; Mrs. William R. Tindall, president of Indiana Auxiliary; Dr. Elton Trueblood, Earlham College, guest speaker; Mrs. Joseph E. Dudding, president-elect; the Rev. Robert W. Fribley, Mrs. Marion W. Hillman, Mrs. E. J. DeGrazia, Mrs. J. M. Black.

Second row, left to right: Mrs. John M. Sullivan, Mrs. Kenneth H. Brown, Walter L. Portteus, M.D., Mrs. Morris D. Wertenberger, Mrs. Elwood Meredith, Mrs. Charles F. Voyles, Russell L. Malcolm, M.D., James A. Waggener, ISMA executive secretary, Mrs. Glen Ward Lee, Mrs. Philip T. Holland, and Mrs. H. O. Williams.

Pictured, below, are several groups taken at the Spring breakfast in the Leland Hotel. They include officers and chairmen.

Reading from left to right are Mrs. L. W. Painter, Mrs. Paul Sparks, Mrs. Jack Shields, Mrs. I. S. Hostetter, Mrs. Robert Acher, Mrs. W. B. Matthew, Mrs. Frank Green, Mrs. Robert Flanders, Mrs. W. R. Tindall, Mrs. J. E. Dudding, Mrs. A. D. Schaaf, Mrs. L. A. Laird, Mrs. Paul L. Stier, Mrs. F. B. Mountain, Mrs. Frederick H. Simmons, and Mrs. H. T. Goodman.

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Deaths . . .

George Hancock Warne, M.D., 76, Tipton physician for the last 40 years, died April 5 in Robert W. Long Hospital, Indianapolis. He had been ill for 18 months. Death was caused by carcinoma.

A native of Franklin county, Dr. Warne received his medical degree from Indiana Medical College, School of Medicine of Purdue University, at Indianapolis in 1906. From 1908 to 1914 inclusive he served with the United States government in the constabulary of the Philippine Islands where he held the rank of first lieutenant. He was director of a constabulary hospital. While in the Philippines he held membership in the Philippine Islands Medical Association.

Dr. Warne was a member of Tipton County Medical Society, was a Fifty Year Club and senior member of the Indiana State Medical Association, and a member of the American Medical Association.

Edgar W. Murphy, M.D., 55, died in his home in New Albany on April 6.

Dr. Murphy was in general practice in Lanesville until 1947 when he established his practice in New Albany, specializing in dermatology. He was a 1931 graduate of the University of Louisville School of Medicine.

Dr. Murphy was a member of the Floyd County Medical Society, the Indiana State and American Medical Associations.

Silva I. Green, M.D., 76, St. Bernice, died April 8 in Vermillion County Hospital, Clinton. He had been in ill health and in semi-retirement since 1953.

Dr. Green, a Scott County native, received his degree in medicine from the Kentucky School of Medicine at Louisville in 1907. He went to St. Bernice in Vermillion county to practice in 1911 and had served a wide area for many years. During World War I he served in the Army Medical Corps. Dr. Green was elected township trustee for the period between 1941 and 1949.

He was the first commander of the Osborn American Legion Post, held church membership, and was a member while in active practice of the Parke-Vermillion County Medical Society, the Indiana State and American Medical Associations. Dr. Frederick G. Greene, Bloomingdale, is a brother.

Harry Allen Van Osdol, M.D., 76, Indianapolis ear, nose and throat specialist for 45 years, died April 10 at his farm near Carmel. He had been in retirement since 1955 and spent much time at his farm where he raised registered horses and cattle.

Dr. Van Osdol was born in Rising Sun, attended the University of Louisville, and was graduated from Indiana University School of Medicine in 1909. During World War I he served as a captain in the Medical Corps.

Throughout his career, Dr. Van Osdol took frequent postgraduate courses, wrote numerous papers for state and national medical publications, and was active in medical organizations. He was a former president of the Marion County and Indiana State Societies of Ophthalmology and Otolaryngology, and before his retirement was a member of General, St. Vincent's and Methodist Hospital staffs, Indianapolis. He was an emeritus professor at Indiana University School of Medicine.

Dr. Van Osdol was a member of church, social, patriotic and lodge organizations, was a senior member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association and the American College of Surgeons.

Jesse L. Jackson, M.D., retired Indianapolis physician and surgeon, died April 21 in his home after an illness of two years. He was 72.

Born in Wabash County, Dr. Jackson had lived in Indianapolis for nearly 50 years. He received his degree in medicine from Indiana University School of Medicine in 1914. He served his internship at Indianapolis City Hospital and later was chief of staff there. He was also a member of staffs of Methodist, St. Vincent's and St. Francis Hospitals.

Dr. Jackson held membership in church and many lodge groups. He was a member of the

Indianapolis Medical Society, the Indiana State and the American Medical Associations.

John F. Beardsley, M.D., 35, Frankfort general practitioner for 10 years, died in diabetic coma in Clinton County Hospital May 5 a few hours after being admitted.

He was born in Frankfort, was a graduate of Franklin College, and received his medical degree from Hahnemann Medical College of Philadelphia in 1946. He served his internship at Indianapolis General Hospital in 1946-1947 and then established his practice with his father, Dr. Frank A. Beardsley, in Frankfort.

Dr. Beardsley held membership in church, social, lodge and fraternal organizations. He was a member of the Clinton County Medical Society, the Indiana State and American Medical Associations.

Dr. Frank A. Beardsley, Frankfort, is a brother.

Elmer W. Nahrwold, M.D., 50, died in Parkview Memorial Hospital, Fort Wayne, May 5 following a long illness.

Dr. Nahrwold was a surgeon, was formerly chief of staff at St. Joseph's Hospital, Fort Wayne, and was a member of the Board of Trustees of the Fort Wayne (Allen County) Medical Society.

Dr. Nahrwold was graduated in 1932 from St. Louis University School of Medicine, and served his internship and residency at the St. Louis University Hospitals. During World War II he served as a major in the U.S. Air Corps.

He was a member of the Fort Wayne Medical Society, the Indiana State and the American Medical Associations.

Anton Stockl, M.D., 63, who had practiced since 1926 in the Calumet area, died April 28 a few hours after successfully delivering a baby in St. Margaret's Hospital. He had been called to the hospital by a Gary patient at 4:30 a.m. and collapsed immediately after delivering the child.

Dr. Stockl was a 1924 graduate of the General Medical College of Chicago, served his internship in the Calumet area and established his office in Lansing, Illinois, in 1926. He was unmarried and left no immediate survivors.

Dr. Stockl was a member of the Lake County (Indiana) Medical Society, the Cook County (Illinois) Medical Society and the American Medical Association.

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INTENSIVE POSTGRADUATE COURSES

STARTING DATES — SUMMER-FALL, 1957

SURGERY—
Surgical Technic, Two Weeks, July 15, August 19
Surgery of Colon & Rectum, One Week, September 16
Basic Principles in General Surgery, Two Weeks, July 8
Surgical Anatomy & Clinical Surgery, Two Weeks, September 30
General Surgery, Two Weeks, September 23
Gallbladder Surgery, Three Days, June 24
Surgery of Hernia, Three Days, June 27
Treatment of Varicose Veins, September 9
Fractures & Traumatic Surgery, Two Weeks, June 17

GYNECOLOGY & OBSTETRICS—
Office & Operative Gynecology, Two Weeks, September 16
Vaginal Approach to Pelvic Surgery, One Week, September 9
General & Surgical Obstetrics, Two Weeks, September 30

MEDICINE—
Electrocardiography & Heart Disease, Two-Week Basic Course, July 8

RADIOLOGY—
Diagnostic X-Ray (the formal course), Two Weeks, September 16
Diagnostic X-Ray (the formal course), Two Weeks, September 16
Diagnostic X-Ray, Clinical Course, by appointment
Radium Therapy, One Week, June 24

CYSTOSCOPY—
Ten-Day Practical Course by appointment

PEDIATRICS—
Neuromuscular Diseases; Cerebral Palsy, July 8

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NEWS NOTES—from State and Nation

Indiana Physician to Study Under Dr. Paul Dudley White

Dr. Arthur H. Griep, who has been associated with Welborn Clinic, Evansville, since 1948, will go to Harvard Medical School, Boston, early in June where he will do postgraduate work in cardiovascular diseases under the eminent heart specialist, Dr. Paul Dudley White. Dr. Griep is one of 12 selected from throughout the nation to take the special advanced study.

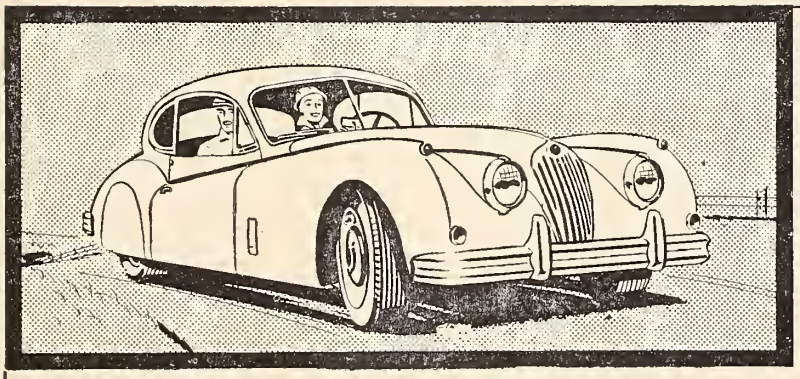
The Evansville specialist has resigned from the Welborn staff. He plans to enter private practice in Evansville when he completes approximately a year's work in Boston.

Dr. George W. Wright, director of medical research for St. Luke's Hospital, Cleveland, was the guest speaker on May 8 at the first of a series of quarterly meetings to be held in St. Mary's Hospital, Evansville. The meetings with a prominent lecturer as guest speaker will replace the annual staff dinner. Dr. Wright is a former resident of Evansville and a 1932 graduate of Indiana University School of Medicine. He is a leading authority on diseases of the chest.

Postgraduate Gastroenterology Course to Be Held in Boston

The American College of Gastroenterology announces that its Annual Course in Postgraduate Gastroenterology will be given at The Somerset in Boston, Massachusetts, on October 24, 25 and 26, 1957.

The course will again be under the direction and co-chairmanship of Dr. Owen H. Wangensteen, Professor of Surgery of the University of Minnesota Medical School, who will serve as surgical co-ordinator and Dr. I. Snapper, Direc-



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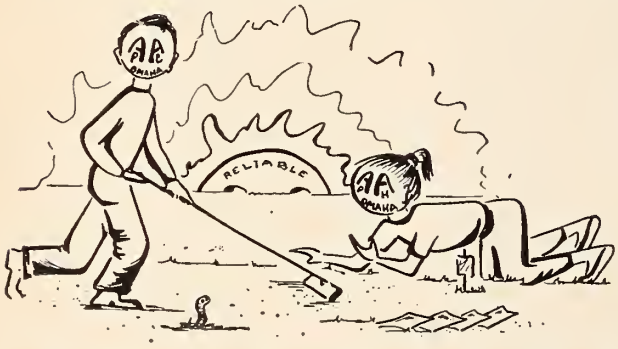
tor of Medical Education, Beth-El Hospital, Brooklyn, N. Y., who will serve as medical coordinator. Drs. Wangensteen and Snapper will be assisted by a distinguished faculty selected from the medical schools in the Boston area.

The subject matter to be covered in the course, from a medical as well as surgical viewpoint, will include, essentially, the advances in diagnosis and treatment of gastrointestinal diseases and a comprehensive discussion of diseases of the mouth, esophagus, stomach, pancreas, spleen, liver and gallbladder, colon and rectum, with special studies of radiology and gastroscopy.

For further information and enrollment write to the American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

Among the Indianapolis physicians who attended the recent meeting of the American College of Allergists in Chicago were: Drs. Irvin Caplin, Kenneth L. Craft, Joseph D. Howell, Bennett Kraft, Mark H. Mothersill, and Donald J. White.



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The Sixth Annual Symposium for General Practitioners on Tuberculosis and Other Chronic Pulmonary Diseases will be held in Saranac Lake, New York, from July 8 to 12. It is approved for 26 hours of formal credit to members of the American Academy of General Practice.

Sessions will be held in the various sanatoria, hospitals and laboratories in the area. The faculty will consist of physicians, surgeons and scientists from Saranac Lake as well as guest lecturers.

Excellent housing accommodations are available. If doctors are accompanied by their families they may enjoy the many vacation facilities of the Adirondack Mountains. So that families may have the use of the family car, bus transportation will be furnished free to the various meeting places.

Information and copies of the program may be obtained by writing Dr. Henry W. Leetch, General Chairman, Symposium for General Practitioners, P. O. Box 11, Saranac Lake, New York. Registration fee for the five-day symposium is $40.

Dr. O. T. Kidder, superintendent of Irene Byron Hospital, Fort Wayne, was recently elected to a three-year term as president of the Allen County Tuberculosis Association.

Dr. R. A. Fargher, LaPorte, was named president of the Northern Tri-State Postgraduate Medical Association at the organization's 84th annual meeting April 11 in Toledo. Physicians from northern Indiana, Northern Ohio and Southern Michigan are members of the Tri-State Association.

Dr. James R. S. Himebaugh, a native of Clark county, has returned to Sellersburg where he has opened an office for the general practice of medicine at 219 North New Albany Street. He is a 1942 graduate of Indiana University School of Medicine, served for four years in the Army Medical Corps during World War II and returned to service during the Korean War as chief surgeon of the Seventh Division. He was injured while making a parachute jump in Korea

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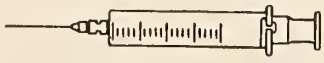

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and was discharged after hospitalization. Dr. Himebaugh then returned to practice in Indianapolis and later in Atlanta. Dr. and Mrs. Himebaugh and their daughter live in Creston.

Diabetes Society Offers "The Opportunity They Need"

This summer the Indianapolis Diabetes Association, Inc. will sponsor the James Whitcomb Riley camp for diabetic children for the third consecutive year. The camp will operate three weeks between June 23 and July 13 inclusive and it will again use the highly specialized facilities developed for handicapped children by the Riley Memorial Association and Indiana University. The camp is located in the Bradford Woods Outdoor Education area six miles north of Martinsville.

Herbert Montgomery of New Castle, aided by a competent staff of counselors, will again direct camping activities of the children. Diabetic boys and girls, ages 8 to 16, are eligible on a non-sectarian basis.

The campers are under constant medical and nursing care; qualified dietitians supervise dietary needs and a well equipped laboratory is operated for all necessary tests incident to the control of the child's diabetes.

Applications will be accepted only for the full three weeks, since the child will not obtain the maximum benefit from a shorter period. The fee for the three weeks is $150.00 and is all inclusive. Limited funds may again be available to modify the fees in selected cases.

Applications may be obtained from and inquiries addressed to: Indianapolis Diabetes Association, Inc., Society of Lay Members, 68 Kenmore Road, Indianapolis, Indiana.

Dr. H. Glenn Gardiner, East Chicago, was reelected secretary of the Industrial Medical Association at its annual meeting in St. Louis April 24. Dr. Gardiner is medical director of Inland Steel Company, East Chicago.

Continued

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News Notes (continued)

Congress of Legal Medicine Scheduled for Chicago in July

The First American Congress of Legal Medicine and Law-Science Problems will be conducted by the Law-Science Institute at the Hotel Morrison, Chicago, Monday, July 8 to Saturday, July 13, 1957 inclusive and also from Monday, July 15 to Saturday, July 20 inclusive, with the aid and cooperation from the Law-Science Academy of America and the Law-Science Foundation of America. Further information may be obtained by addressing Dr. Hubert W. Smith, Law-Science Institute, University of Texas, Austin 12, Texas.

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98 Physicians and Attorneys Attend Muncie Meeting

On Tuesday night, April 30, the Delaware-Blackford County Medical Society entertained the lawyers of both counties at a dinner meeting at the Delaware Hotel in Muncie. Ninety-eight physicians and lawyers attended and after a social hour together followed by dinner they viewed the newly published moving picture film, "The Medical Witness," which has been produced by the Legal Bureau of the American Medical Association as the first in a series of films on Medicine and the Law. Following the showing the group discussed the film and its implications, particularly as applicable to local problems. Such meetings as this offer an excellent opportunity for the exchange of ideas, and in some localities the outcome of such collaboration has been the development of Medico-Legal Codes which then have formed a useful basis for interprofessional understanding and a guide for both physicians and lawyers in working out any problems in matters of medico-legal procedure.

This is the first film in a series on Medicine and the Law which is being produced by The Wm. S. Merrell Company, pharmaceutical research laboratories, in cooperation with the American Medical Association and the American Bar Association, as a timely service to the medical and legal professions.

Indiana Nurses Attend Congress Held in Rome, Italy

Twelve Indiana nurses attended the Eleventh Quadrennial Congress of the International Council of Nurses in Rome, Italy, from May 27 to June 1. The Council, a federation of 37 national professional nurses' associations, has 450,000 members. The American Nurses Association, with 175,000 members, has been affiliated with the Council since 1904.

Those attending from Indiana were: Mrs. Genevieve Beghtel, president of INSA, Indian-

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apolis; Elsie Norman, director of nurses, Protestant Deaconess Hospital, Evansville; Martha Warstler, educational director, Reid Memorial Hospital, Richmond; Fern Dumbald, an anesthetist at Methodist, Indianapolis. Also attending were Mrs. Verdun Glueck, executive secretary, Cancer Society, Gary; Alberta Wadey, executive director of Visiting Nurses Association, Gary; Mrs. Lillie Riggs, industrial nurse, Indianapolis; Patricia Feltz, Air Force Nurse Corps; Mrs. Marie d'Andrea Logan, educational director, St. Vincent's, Indianapolis; and Mrs. Inez Stierwalt, private duty, Indianapolis.

Student nurses who attended the ICN included Susanne Jackson, president of the Indiana Association of Student Nurses, and Mrs. Dorothy Slaton, a senior student at Evansville College, Baptist Hospital School of Nursing, Evansville.

Indianapolis Physician Presides at Psychiatric Hospitals Meeting

Dr. Philip B. Reed, Indianapolis, was presiding officer at the May 11-12 meeting in Chicago of the National Association of Private Psychiatric Hospitals. Dr. Reed was president of the organization.

Following the hospital meeting, Dr. Reed served as a discussant for a paper on "The Role of Relatives in the Psychotherapeutic Program" at the meeting of the American Psychiatric Association.

Other members of the Norways Hospital staff who attended the APA sessions were Drs. David L. Phillips, William A. Wood, Millard L. Hoyt, John E. Kooiker and Vincent Canganelli.

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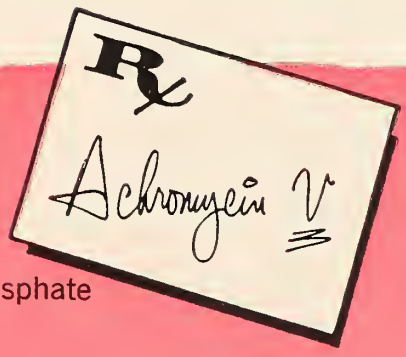

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News Notes (continued)

Dr. Millard L. Hoyt, Indianapolis, discussed "Group Psychotherapy in General Practice" as a member of a panel on Group Psychotherapy, at the recent meeting of the Tri-State Group Psychotherapy Association in Columbus, Ohio. He also attended the meeting of the American Psychosomatic Society in Atlantic City.

Dr. Earl Mericle, Indianapolis, was the guest speaker at a combined meeting of the Lions Club and Tri Kappa sorority in Clinton on May 8. He discussed the mental health problem and recent developments in treatment of mental illness.

Drs. E. Rankin Denny, Terre Haute; **Raymond W. Spenner**, South Bend; **A. D. Dennison, Jr.**, and **John V. Thompson**, Indianapolis, attended the May 15-17 meeting of the American College of Cardiology at the Hotel Willard, Washington, D. C.

Dr. James H. Stygall, Indianapolis, immediate past president of the American College of Chest Physicians, presided at the annual College Conference luncheon on May 30 during the 23rd annual meeting of the American College of Chest Physicians in the Hotel Commodore, New York City. The meeting was held from May 29 through June 2.

Indiana Chapter, ACS, Elects 1957-58 Officers

The 246 members of the Indiana Chapter, American College of Surgeons, who attended the annual meeting in Fort Wayne April 24, elected Dr. Donald W. Ferrara, Peru, president for the coming year.

Other officers named are Dr. R. Morton Bolman, Fort Wayne, president-elect; Dr. W. C. Reed, Bloomington, vice-president; Dr. J. E. Pilcher, reelected secretary-treasurer; and the following counselors: Drs. Russell Malcolm, Richmond; Cecil G. McEachern, Fort Wayne; and James M. Leffel, Indianapolis, the retiring president.

The 1958 meeting of the Indiana Chapter will be held in Indianapolis.

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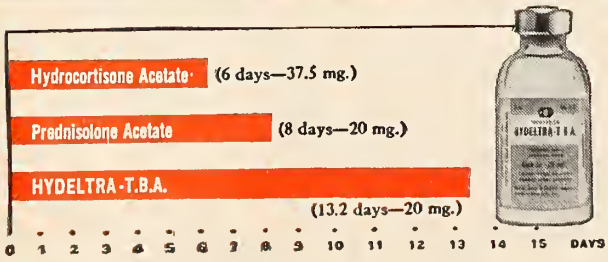

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

The Council

April 28, 1957

The Council of the Indiana State Medical Association convened for its spring meeting at 10:00 a.m., Sunday, April 28, 1957, in Room M-124, Indiana University Student Union Building, Indianapolis, with Dr. Guy A. Owsley, chairman, presiding.

Roll call showed the following present:

Councilors:

First District—William B. Challman, Mount Vernon
Second District—Sam I. Rotman, Jasonville, alternate
Third District—Keith Hammond, Paoli
Fourth District—J. E. Dudding, Hope
Fifth District—M. C. Topping, Terre Haute; V. Earle Wiseman, Greencastle, alternate
Sixth District—Harry P. Ross, Richmond; W. R. Tindall, Shelbyville, alternate
Seventh District—Ralph V. Everly, Indianapolis
Eighth District—Guy A. Owsley, Hartford City; Gordon B. Wilder, Anderson, alternate, and AMA delegate
Ninth District—Wemple Dodds, Crawfordsville; Kenneth O. Neuman, Lafayette, alternate
Tenth District—James P. Vye, Gary; Ralph C. Eades, Valparaiso, alternate
Eleventh District—Max R. Adams, Flora
Twelfth District—Maurice E. Glock, Fort Wayne
Thirteenth District—G. O. Larson, LaPorte; Benedict A. Biasini, South Bend, alternate

Officers:

Elton R. Clarke, Kokomo, president
M. C. Topping, Terre Haute, president-elect
O. W. Sicks, Indianapolis, treasurer

Journal:

Frank B. Ramsey, Indianapolis, editor
A. W. Cavins, Terre Haute, associate editor
David A. Bickel, South Bend, associate editor

Executive Committee:

James W. Denny, Indianapolis, chairman
E. H. Clauser, Muncie
Albert Stump, attorney
Robert Hollowell, attorney
Robert J. Amick, field secretary
Kenneth W. Bush, field secretary
J. A. Waggener, executive secretary

Guests:

Cleon A. Nafe, Indianapolis, AMA delegate
E. S. Jones, Hammond, AMA delegate
Earl W. Mericle, Indianapolis, AMA alternate delegate, and chairman, Committee on Public Relations
J. William Wright, Sr., co-chairman, Committee on Public Policy and Legislation
Lester D. Bibler, Indianapolis, member, Liaison Committee with American Legion, Indiana Hospital Association, and Indiana State Dental Association
Harry E. Klepinger, Lafayette, chairman, Committee on Medical Education and Licensure
Edward B. Smith, Indianapolis, chairman, Coroner System Study Committee
George S. Bond, Indianapolis, chairman, Committee on Heart Disease
Paul T. Lamey, Anderson, secretary, Indiana State Board of Medical Registration and Examination
William N. Wishard, Jr., Indianapolis, member of Indiana State Board of Medical Registration and Examination
Ruth V. Kirk, Indianapolis, executive secretary, Indiana State Board of Medical Registration and Examination
Andrew C. Offutt, Indianapolis, State Health Commissioner

By consent, the minutes of the January 20, 1957, Council meeting were approved as printed in the March 1957 issue of The JOURNAL.

REPORTS OF COUNCILORS

The councilors announced the dates of their spring district meetings and extended invitations to the officers and all who might wish to attend these meetings.

Dr. Challman, First District, spoke of the experience of the Vanderburgh County Medical Society with the polio vaccination program, where the membership was forced to set up three public clinics. "About half of the available injections were given in the free clinics. . . . The County Society did not like it and they do not intend to do it again; they feel that it is the responsibility of the families of these children and the private physicians to see that they get the injections. If they can't pay for it, well and good, that it be furnished by some government agency, but they feel that it is not the duty of the Medical Society to go out and grab these people and drag them in and give them a shot if they don't want it."

Dr. Larson, Thirteenth District, introduced Dr. Ben Biasini, South Bend, alternate councilor of the Thirteenth District. (Applause.)

For the information of the Council, Dr. Larson called attention to the Federal Grand Jury investigation now in progress regarding monopoly and restraint of trade and involving the Illinois and Indiana State Dental Associations, their component societies, and their officers back to and including 1954.

REPORTS OF OFFICERS

Dr. Elton R. Clarke, president: "We are right in the thick of things now, having a good many special meetings. I am glad to say the committees are showing lots of activity. It is a little difficult to accept all these invitations. I appreciate being asked to your committee meetings, although I may not be able to get to all of them. The District meetings will be coming on now, this month and next, and we are getting around to as many of these different events as we can. We may have something to say about some special things that we have participated in later."

Dr. O. W. Sicks, treasurer, reported total investments in bonds, U. S. Treasury Bills and Certifi-

cates of Indebtedness of $272,000, and a cash balance of $50,487, making a total of $322,487, as of March 31, 1957, in the General Fund, Medical Defense Fund and Student Loan Fund.

Dr. Frank B. Ramsey, editor of The JOURNAL, announced that the Editorial Board was meeting at this time and would have lunch with the Council members.

UNFINISHED BUSINESS

1. *American Medical Education Foundation Fund.* Dr. H. E. Klepinger, chairman of the Committee on Medical Education and Licensure, reported contributions from Indiana to the A.M.E.F. during the past four years as follows: 1954, $49,868.62; 1955, $24,963.91; 1956, $19,075.00; 1957, $4,052.50. "There are probably two or three reasons for this progressive spiral downward, one being an inadequate or insufficient amount of matter from the Medical School as to why they need money, and the other reason being that nearly all the doctors, or a great proportion of them who have contributed, feel they have carried the load long enough and it is time for their neighbor to contribute also.

"At the national level there has been a 25 percent increase in the past year in contributions, the reason for that being that many of these states that did not contribute in the early years are now beginning to contribute; but the principal reason is that a number of the larger states have increased their dues to cover this. Illinois, as everyone knows, increased their dues twenty dollars, a year or so ago; California, $25; and there are about six or seven other states that have increased their dues an average of $15; all in all, bringing that increase of 25 percent.

"The Committee on Medical Education feels more strongly this year than ever before that the State Association should investigate still more the likelihood of increasing its dues in an amount equal to what would be required to cover Indiana's quota."

Dr. Denny reported that up to date Indiana University School of Medicine had received $302,000.00 from A.M.E.F., and this year the Association will give the University a total of $92,000.00.

Dr. Elton R. Clarke: "At the A.M.E.F. meeting in Chicago, which we attended, the idea was brought up as to what effect increasing dues would have on the voluntary gifts. Strange to say that in some of the states where that has been tried they report that not only it doesn't stop them, but actually they have increased their voluntary giving after this compulsory or stated amount had been voted into effect, so that I don't think we need to be afraid of injuring our general contributions, according to the experience of some of these other states. I would like to see it done."

On motion of Drs. Dodds and Vye, the Council voted to recommend to the House of Delegates that the membership dues of the Indiana State Medical Association be increased $10.00 per year, this amount specifically for A.M.E.F.

2. *Student Loan Fund.* Dr. Ross, chairman, reported that his committee had processed four more applications and had negotiated loans to these four students. Two more applications are being processed. He also reported that the Board of Trustees of Indiana University had increased the interest rate on all student loans from 3 to 5½ per cent—throughout the University, not just the Medical School.

3. *Science Fair.* At the request of Dr. Earl W. Mericle, chairman of the Committee on Public Relations, and upon motion of Drs. Vye and Ross, the Council voted to send three representatives from the Indiana State Medical Association to the Science Fair in Los Angeles, May 8-12, 1957. On motion of Drs. Larson and Vye, Dr. Harry Pandolfo, Indianapolis, Dr. Eades and one of the field secretaries are to be asked to make the trip to Los Angeles. The field secretary is to take pictures and bring back publicity.

Dr. Glock called the Council's attention to the fact that while newspaper publicity on the Science Fair held recently in his community was excellent, no mention was made of the Indiana State Medical Association and its part in promoting these fairs. Discussed by Drs. Mericle, Eades and Denny.

4. *Report of Coroner System Study Committee. Dr. Edward B. Smith*, chairman of the special committee appointed to study the coroner system, presented the following report:

The committee met at the Student Union Building at the Indiana University Medical Center at 5 p.m., Thursday, April 25, 1957.

Committee members present: R. Perry Reynolds of Garrett (DeKalb County); Lall G. Montgomery of Muncie (Delaware County); Edward B. Smith (Chairman) of Indianapolis (Marion County). Absent: Joseph Dudding of Hope (Bartholomew County). Also present was Mr. Robert Hollowell, Legal Counselor of the Association.

There was a preliminary discussion of what is legally possible as regards any change in the present constitution, laws or court decisions regarding the coroner. Any thoughts regarding improvement in the coroner's system must recognize that: (1) the office of coroner is a constitutional one and the Constitution permits any willing voter the possibility of becoming coroner, without regard for his other qualifications; (2) the coroner has limitations on his jurisdiction as regards which cases he may investigate and examine; and (3) the coroner has insufficient help.

Note was made of the passage by the Indiana State Legislature of House Bill 195 which creates a department of toxicology at Indiana University School of Medicine, with an appropriation of approximately $50,000 for a two year period.

Note was made of the introduction of a House

Resolution, House Resolution No. 20, passed March 5, 1957, by the House of Representatives of the 90th Indiana General Assembly (1957). This resolution authorized appointment by the chairman of the Legislative Advisory Committee of a subcommittee of the Legislative Advisory Committee for the purpose of investigating the need for a Department of Forensic Sciences at Indiana University or elsewhere in the state. The subcommittee will probably include a representative of (1) the Indiana State Medical Association, (2) Indiana University School of Medicine, (3) Indiana Bar Association, (4) Indiana University Law School, (5) Indiana Pathologists Association, (6) Indiana Coroners Association, and (7) Indiana State Police.

The duties of the subcommittee should be to study the needs of the coroners and other law enforcement agencies with the view to determine the feasibility of establishing a bureau or department of forensic sciences at Indiana University or elsewhere in the state, and to report to the 91st General Assembly.

After further discussion two programs of action were considered:

I. A *long range program* designed to encourage physicians to accept nominations for the office of coroner and to help the coroner in the interests of service to the public; the program designed also to promote an Indiana state constitutional amendment in which the Legislature might define the qualifications and duties of the coroner.

(The Bar Association would possibly be interested in a similar amendment to authorize the Legislature to define the qualifications and duties of Judges of Circuit Courts.) (Note: Such amendments must pass by a majority in each branch of the General Assembly. Then it must pass by a majority in each branch two years later at the next General Assembly. Finally, it must be approved by a majority of the voters who vote on the amendment in a general election throughout the state.)

II. An *immediate program* to find ways to aid the coroner through establishment of any helpful facilities. The Coroner System Study Committee of the ISMA has reason to believe that the Governor will soon appoint a subcommittee to investigate the need for a department of forensic sciences at Indiana University or elsewhere in the state. It is recommended that the Council of the ISMA be prepared to propose the names of three persons one of whom the Governor may appoint to membership on the subcommittee to investigate the need for a department of forensic science at Indiana University or elsewhere in the state.

Following discussion by Drs. Dudding, Glock and Smith, it was taken by consent that the Coroner System Study Committee be allowed to make its own nominations for representatives on the Governor's Committee.

5. *Revision of A.M.A. Code of Ethics.* On motion of Drs. Ross and Dudding, the Council voted that any recommendation regarding revision of the following sections of the A.M.A. Code of Ethics be left to the discretion and judgment of Indiana's A.M.A. delegates:

> *Section 6:* A physician should not dispose of his services under terms and conditions which will interfere with or impair the present and complete exercise of his independent medical judgment or skill or cause a deterioration of the quality of medical care.
>
> *Section 7:* In the practice of medicine, a physician should limit the source of his professional income to medical services actually rendered by him to his patient.

6. *Employment of non-medical person in psychiatrist's office.* Letter received from the Judicial Council of the A.M.A., in reply to an inquiry from the Indiana State Medical Association, follows:

"The Judicial Council will not meet until early

Continued

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More than two years of clinical evaluation have proven Harmonyl a notably safe and effective agent in cases ranging from mild anxiety to major mental illnesses and in hypertension. Harmonyl exhibited significantly fewer and milder side effects in comparative studies with reserpine—while demonstrating effectiveness comparable to the most potent forms of rauwolfia.

Safety—plus marked clinical effectiveness

Harmonyl proved particularly effective, for example, in tranquilizing a group of 40 chronically ill, agitated senile patients.[1]

Of particular interest is the observation that patients became more lucid and alert on Harmonyl therapy. And there was a complete absence of side effects with Harmonyl—although a similar group on reserpine developed such side effects as anorexia, headache, bizarre dreams, shakes, nausea and vomiting.

Following another eight-month study of chronic, hospitalized mental patients, Ferguson[2] stated:

- Harmonyl benefited at least 15% more overactive patients and proved more potent in controlling aggression—requiring only one-half to two-thirds the dosage of reserpine.
- Patients experiencing side reactions on reserpine often were completely relieved when changed to Harmonyl.

Ferguson concluded: "*The most notable impressions were the absence of side effects and relatively rapid onset of action with Harmonyl.*"

Comparative studies have shown Harmonyl and reserpine about equal in hypotensive effect. The tranquilizing action of the two drugs also appeared similar—except that few cases of giddiness, vertigo, sense of detached existence or disturbed sleep were seen with Harmonyl.

Professional literature is available upon request. Harmonyl is supplied in 0.1-mg., 0.25-mg., and 1-mg. tablets.

Abbott

References: 1. Communication to Abbott Laboratories, 1956. 2. Ferguson, J. T.: Comparison of Reserpine and Harmonyl in Psychiatric Patients: A Preliminary Report, Journal Lancet, 76:389, December, 1956. *Trademark

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June. Consequently, an official answer to your inquiry cannot be had immediately.

"I may say, however, that at one of its recent meetings the Judicial Council was asked if it is ethical for a clinical psychologist to do psychotherapy under the supervision of a doctor of medicine specializing in Psychiatry. The Judicial Council reached the opinion that in itself the relationship is not unethical. The Council expressed the further opinion that the relationship between a psychiatrist and the psychologist must be evaluated, however, according to the facts, and only the local medical society may ascertain these facts and thereupon evaluate the ethical propriety of any given situation.

"If you wish, and if you could advise me, I will present your inquiry to the Council at its next meeting."

It was taken by consent that the psychiatrist making this inquiry would have to use his own judgment until a ruling is received from the A.M.A. Judicial Council.

1957 ANNUAL SESSION, FRENCH LICK OCTOBER 7, 8 and 9, 1957

1. *Scientific exhibits.* The secretary read a letter from Dr. A. W. Ratcliffe, chairman of the Committee on Scientific Exhibits, in which he reported three applications for space have been received and several others are outstanding. The report continued:

"Particularly in Evansville there has been expressed dissatisfaction with exhibit space in the French Lick Springs Hotel Convention Hall and its foyer. This appears chiefly due to the feeling (from previous exhibit experience) that the traffic here is light as compared with that in the main building. This feeling is definitely standing in the way of some potential exhibits.

"It is respectfully urged that the Council consider ways and means to alleviate this situation either along the line of relocating these exhibits or of stimulating better traffic flow. (If the plan of having attendance at commercial exhibits verified by rubber-stamp mark is to be again used, might it also include the scientific exhibits?)"

On motion of Drs. Dudding and Challman the above report was accepted.

2. *Scientific program.* The secretary presented an outline of the program, as completed by the Scientific Work Committee, calling attention to the fact that the committee had voted to dispense with section meetings and hold only general scientific meetings in 1957. It has been suggested that the sections plan luncheon meetings for the purpose of conducting the business of the various sections. Briefly, the program will be as follows:

Sunday, October 6

Meetings of Executive Committee, Council and House of Delegates.

Monday Morning, October 7

Annual golf tournament and trap shoot
Meetings of Reference Committees

10 to 12	Instructional courses
12 noon	Indoctrination luncheon for all new members

Monday Afternoon, October 7

Reference Committees meet

2 to 5	General Scientific Meeting

Monday Evening, October 7

Smoker and stag party
Entertainment for physicians, wives and guests

Tuesday Morning, October 8

Breakfast meetings of committees and special groups

8 to 10	Instructional courses
9:30 to 12	General Scientific Meeting
Noon	Luncheon meetings of fraternities, sections, and committees

Tuesday Afternoon, October 8

2 to 5	General Scientific Meeting

Tuesday Evening, October 8

President's night
Entertainment

Wednesday Morning, October 9

Breakfast meetings of committees and special groups

9:30 to 12	General Scientific Meeting
Noon	Luncheon meetings of fraternities, sections, and special groups

Wednesday Afternoon, October 9

12:30	House of Delegates meeting
	Council and Executive Committee meetings
5:30	Reception for members of Fifty-Year Club

Wednesday Evening, October 9

Annual Dinner

By consent, the above outline was approved.

LEGISLATIVE MATTERS

1. *Dr. J. William Wright,* co-chairman of the Committee on Public Policy and Legislation, presented the final report of his committee on legislation which was passed by the 1957 General Assembly. "Over five hundred bills were presented in each branch of the Legislature. A great many of

Continued

these contained some reference to medical problems. Only three or four bills had a direct bearing on medical problems: (1) Hospital bill; defeated; (2) Bill requiring full citizenship to take State Board examination and to practice in Indiana; defeated; (3) Dispensing optician bill; no action by committee; (4) Chiropractic bill. Failed for lack of constitutional majority 23 to 20.

"The bill presented by your State Association to require the registration of all household products containing poison with the Indiana State Board of Health and identifying the poison was passed by the House by a vote of 69-0 and final action taken by the Senate by a vote of 41-2."

Dr. Wright thanked the headquarters staff for "the excellent service and attention they gave to this committee during the session of the Legislature."

On motion of Drs. Everly and Dudding, the Council voted appreciation to the Legislative Committee for its splendid work during the Legislature.

2. *Dr. Mericle, chairman of the special committee to investigate the recodification of the mental health laws in Indiana,* reported that his committee would spend the summer on this problem and try to have a report ready at the time of the annual convention at French Lick.

NEW BUSINESS

1. *Remission of state dues.* On motions of Drs. Glock and Everly, and Dudding and Challman, the Council voted remission of the state dues of one member each in Allen and Spencer counties, both of whom have retired due to illness.

2. *Matters referred to Council by Executive Committee.*

a. *Budget. Dr. James W. Denny,* chairman, presented the 1957 budget which had been compiled by the Executive Committee, showing estimated receipts of $126,714, and estimated expenditures of $135,440, which is about $13,500 less than the 1956 budget and about $7,400 more than was actually spent in 1956.

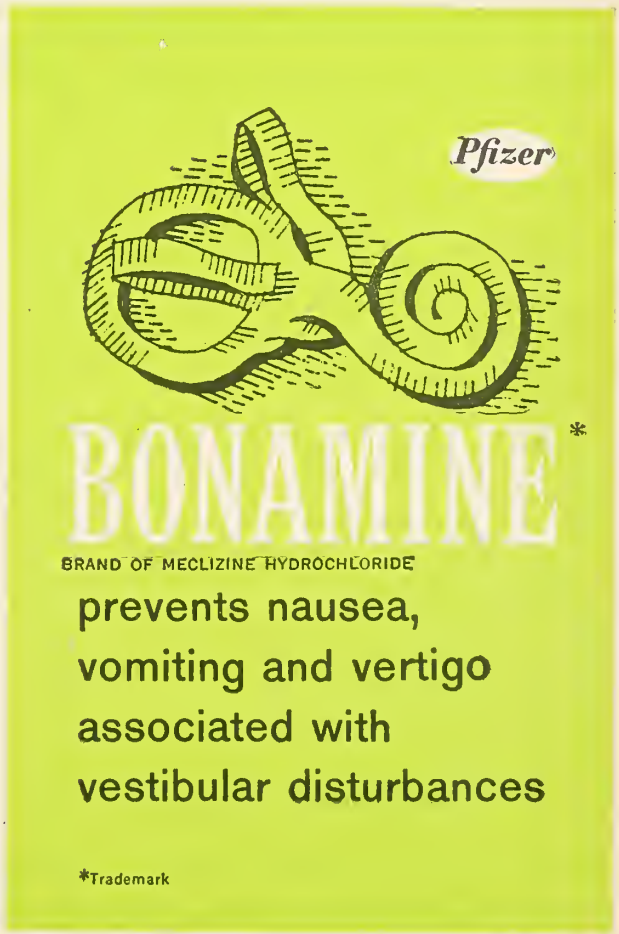
The budget figures for 1956 showed that $1,610 of the $10,000 transferred from the General Fund to the Student Loan Fund was used in 1956. On motion of Drs. Glock and Dudding, the Council appropriated an additional $5,000 to the Student Loan Fund.

On motion of Drs. Everly and Glock, the Council approved the 1957 budget.

b. *Contract with St. Paul Mercury Indemnity Company.* Dr. Denny reported that Mr. Don Hawkins, assistant secretary of the St. Paul Fire and Marine Company, had appeared before the Executive Committee at its meeting on April 27. At the present time approximately 558 contracts are in force in Indiana with the St. Paul Company. If this number is increased, rates, which now are about 26 percent lower than most other malpractice insurance in this state, can be further reduced. Mr. Hawkins brought out the fact that his company has no limits, and it has local agents who handle the business, which is an advantage. He proposed that he and Mr. Waggener formulate a letter, to be sent to every member of the Indiana State Medical Association, stating the above facts and advantages, but not soliciting business, and making an effort to secure the expiration date of the members' present malpractice insurance. These dates then will be given to the agents in the various communities for follow-up purposes. The business will be handled entirely through the local agents of St. Paul Mercury. On motion of Drs. Dudding and Vye the Council approved the action of the Executive Committee in fulfilling the agreement with the St. Paul Mercury Indemnity Company.

c. *Medicare contract.* The present contract, which is operating on a "no fixed fee," expires on June 30 and the Government has asked for a renewal until March, 1958, on the present basis. Discussed by Drs. Denny, Sicks and Glock, and Mr. Waggener. On motion of Drs. Ross and Dudding, the Council voted to renegotiate on the present basis and, if possible, try to recover some of the overhead costs from the Government and/or Blue Shield.

d. *A.M.A. Board of Trustees.* On motion of Drs. Dudding and Ross, the Council authorized the dele-



gates to the A.M.A. to use their own judgment in placing in nomination the names of Indiana men to fill any vacancies on the A.M.A. Board of Trustees.

e. Dr. Denny reported that he and Dr. Clarke, president, had written letters to the chairman of the Nominating Committee of the Woman's Auxiliary to the American Medical Association in support of Mrs. Frank Gastineau, Indianapolis, for the office of president-elect. It was taken by consent that the action already taken was sufficient.

3. *Indiana Heart Foundation program. Dr. George S. Bond* explained the program proposed by the Indiana Heart Foundation on work simplification for the cardiac, a companion program to the weight control program which proved so successful. Classes of about twenty each will be organized in the different communities of the state and a series of lectures and demonstrations will be given by trained personnel. "The doctor will always be recognized, and in the application that these people make for forming of the classes, the doctor is to write a letter stating what he thinks about the cardiac status and the amount of work that they can do before they will be entered in the classes. The work would be largely lectures. There may be some demonstrations that will require some effort on the part of patients, but that is not very likely. The Indiana Heart Foundation, before it goes ahead with this project, would like to have the approval of the Council of the Indiana State Medical Association from the doctor's viewpoint."

On motion of Drs. Glock and Dudding, the above program was approved by the Council.

4. *Relationship between medical profession and Blue Shield.* The chairman of the Council announced that he had appointed Dr. Larson, chairman, and Drs. Glock and Hammond members of a committee to investigate the relationship between the profession as a whole and Blue Shield. Dr. Larson reported that his committee would meet soon to compile a questionnaire to be sent to every member of the Association in order to secure the facts.

5. *Veterans' Affairs. Dr. Lester D. Bibler* reported on the Veterans' Affairs meeting which was held in Chicago on January 26, 1957, which Dr. Clarke, Mr. Waggener and he attended. Forty-five men from 18 states were present at that meeting. Among pertinent points discussed were:

(1) Decision of the House of Delegates of the A.M.A. in Seattle which was reaffirmed and which follows:

> "The AMA policy then basically desires that Veterans Administration care be limited to service-connected illnesses. While the present law continues, however, and non-service connected care is provided the priority should be given to those veterans with long-term illnesses which they cannot finance. A short-term case is strictly a local responsibility."

(2) House Bill 58 relative to confirmation of the penalty clause in P-10.

(3) Where is stimulation of accepting non-service connected cases coming from in VA hospitals? The thought was expressed that these so-called non-service connected cases are being brought in for the purpose of education or training for intern and residency programs. Recommendation was made that this be studied more thoroughly.

(4) Home-town care. Group was in agreement that this type of care should be continued.

(5) A new group is being organized known as the National Medical Veterans Association which is very active in supporting the policy of the A.M.A.

Dr. Bibler also spoke of the two meetings of the Joint Liaison Committee of the Indiana State Medical Association which were held on January 16 and April 24, 1957. He presented the following resolution which the Council referred to the Committee on Veterans' Affairs for whatever action it may care to take:

RESOLUTION

1. *Whereas* the Indiana State Medical Association, the Indiana State Dental Association, the Indiana Hospital Association and the Indiana Department, the American Legion, did form a Joint Liaison Committee on Veterans' Affairs in November 1952 and

2. *Whereas* this Joint Committee made up of duly appointed representatives of these organizations have met at least once every three months since that time and

3. *Whereas* each of the organizations above unanimously voted in October 1956 that these meetings continue in spite of cessation of liaison between the American Medical Association and the American Legion on national level because they felt much good had come from these meetings and

4. *Whereas* this Joint Liaison Committee meeting in Indianapolis this 16th day of January 1957 in its 21st quarterly meeting has closely and carefully considered the action of the House of Delegates of the American Medical Association meeting in Seattle, Washington, in December 1956, wherein the policy of that Association on care of veterans in V.A. institutions was revised to deny recognition of the privilege of indigent veterans to medical and surgical care in Veterans' Hospitals and facilities and (see Appendix A)

5. *Whereas* this action would also deny veterans with wartime service care in V.A. facilities for psychiatric and neurological conditions

Continued

designed to **control anxiety**

in Arthritis, Asthma, Allergic Dermatoses

with **lower corticoid dosage**

the original tranquilizer-corticoid

Ataraxoid*

prednisolone and hydroxyzine

provides the emotional tranquilizer, ATARAX® (hydroxyzine) and the preferred corticoid, STERANE® (prednisolone) • control of emotional factors by tranquilization enhances response to the corticoid for greater clinical improvement • often permits substantial reductions in corticoid dosage, accompanied by reduction of hormonal side effects • confirmed by marked success in 95% of 1095 cases of varied corticoid indications[1]

ATARAXOID *now written as* **Ataraxoid 5.0**

5 mg. prednisolone, 10 mg. hydroxyzine hydrochloride, in green, scored tablets. Bottles of 30 and 100.

and now available as **NEW Ataraxoid 2.5**

2.5 mg. prednisolone, 10 mg. hydroxyzine hydrochloride, in blue, scored tablets. Bottles of 30 and 100.

and **NEW Ataraxoid 1.0**

1.0 mg. prednisolone, 10 mg. hydroxyzine hydrochloride, in orchid, scored tablets. Bottles of 100.

formerly **Ataraxoid**
NOW written **Ataraxoid 5.0**

advantages: (1) greater flexibility of dosage (2) effective tranquilization permits lower corticoid dosage

1. Personal communications

*Trademark

PFIZER LABORATORIES *Division, Chas. Pfizer & Co., Inc. Brooklyn 6, New York*

Pfizer

of non-service connected origin, and (see Appendix A)

6. *Whereas* there are still inadequate local facilities to care for indigent veterans suffering from psychiatric and neurological conditions, therefore

7. *Be it resolved,* that the House of Delegates of the American Medical Association should reconsider their action of December 1956 and readopt the more realistic policy on this subject as exemplified in the action of that House of Delegates in 1953, and (see Appendix A)

8. *Be it further resolved,* that based upon the experience of this State and others who have honestly and wholeheartedly followed the policy of informed men of good will sitting around a conference table discussing these matters, we recommend that liaison between the American Medical Association and the American Legion, the American Dental Association and the American Hospital Association on national level be resumed and continued, and

9. *Be it further resolved,* that this Resolution be presented to the delegates of the Indiana State Medical Association for their approval and presentation to the A.M.A. House of Delegates for approval.

This Resolution passed unanimously by the Joint Liaison Committee on Veterans' Affairs of the Indiana State Medical Association, the Indiana Department of the American Legion, the Indiana State Dental Association and the Indiana State Hospital Association meeting in Indianapolis, Indiana, January 16, 1957.

APPENDIX A TO RESOLUTION

Resolution referred to House of Delegates of AMA during Nov. 27-30, 1956, Seattle, Washington, Clinical Session, approved in principle by the House of Delegates. Submitted by H. B. Mullond, Acting Chairman, Council on Medical Services of AMA.

With respect to the provision of medical care and hospitalization benefits for veterans in Veterans Administration and other federal hospitals that new legislation be enacted limiting such care to veterans with peacetime or wartime service whose disabilities or diseases are service incurred or aggravated.

In the approving action, the AMA House of Delegates added the following statement to the foregoing resolution:

"This action eliminates the temporary exceptions which were made in the June 1953 policy regarding wartime veterans who are unable to defray the expenses of necessary hospitalization for nonservice-connected cases of tuberculosis or psychiatric or neurological disorders. In making the policy change the House approves this supplementary statement:

"'We recognize the laws and administrative extensions of the law that are now in operation. We feel that under the circumstances it will be to the best interests of the public in general, and veterans in particular, if medical societies, county and state as well as national, develop committees to assist in guaranteeing VA hospital admission to service-connected cases. While the present law exists, we should help assure that veterans whose illness constitutes economic disaster will not be displaced by those suffering short-time remediable ills which at the worst constitute financial inconvenience.'"

6. *Dr. Andrew C. Offutt,* State Health Commissioner, spoke of the following matters for the information of the Council:

(1) Public Health Service study on the effectiveness of I.N.H. in the treatment of contacts to active cases of tuberculosis, which will be made in Indiana.

(2) Administration of the bill passed by 1957 Legislature requiring the labeling of all household products that contain poisons.

(3) Licensure of nursing homes.

(4) Polio vaccine recommendations:

a. That no Federal controls be established, and

b. That steps be taken to secure additional information on vaccine demands so that manufacturers can set up production schedules to meet needs.

Dr. Offutt asked for the opinion of the Council on a letter which he had prepared, along with a questionnaire, to be sent to all county medical societies; in order to obtain the information necessary to effect recommendation (b). On motion of Drs. Glock, Everly and Challman, this letter and questionnaire were approved by the Council.

(5) Letter from Dr. Thomas Rivers, in which the antigenicity of some of the trial polio vaccine was questioned. Inasmuch as Indiana did not have any of the low potency vaccine during the field trials, the Council took no action on this matter.

7. *Nominations for Editorial Board.* Drs. Ross and Challman nominated Dr. George M. Johnson, Richmond, to succeed himself for the three-year term ending December 31, 1960.

Drs. Everly and Clarke nominated Dr. Irvin W. Wilkens, Indianapolis, to succeed himself for a three-year term ending December 31, 1960.

These nominees will be voted on at the October meeting of the Council.

8. *Summer meeting of Council.* By consent, the next meeting of the Council will be held on Sunday, July 14, 1957, at the Indiana University Student Union Building, Indianapolis.

There being no further business, the meeting was adjourned.

District Meeting Reports

FOURTH COUNCILOR DISTRICT

Dr. William A. Johnson, North Vernon, was elected president of the Fourth District Medical Society at that organization's 53rd Annual Assembly at Greensburg on May 8. Serving with him during the year will be Dr. R. O. Zink, Madison, vice-president; and Dr. Benet W. Thayer, North Vernon, secretary. Dr. J. E. Dudding, Hope, was named to the Blue Shield Board to represent the district.

The day's program began with golf at the Greensburg Country Club. The delegates' meeting convened at noon at the Elks Club. In addition to election of officers and routine business, members heard a report by Dr. Dudding of activities of the Council and the Blue Shield Board. James A. Waggener, ISMA executive secretary, represented Dr. Elton R. Clarke, president, and spoke briefly. Robert J. Amick, field secretary, also attended the meeting.

Following luncheon in the Elks Club, Dr. Robert J. Rohn, director of cancer research at Indiana University Medical Center, spoke on "Hematology in General Practice." He was followed by Dr. Ott McAtee, superintendent of Madison State Hospital, who discussed "Your State Hospital and General Practice."

Sixty-two members and guests attended the meeting.

The District Auxiliary meeting was held simultaneously in the Elks Club, opening with a coffee hour and business meeting. Following luncheon members attended a theater party and then were guests at a tea in the home of Dr. and Mrs. Robert Acher. Mrs. J. E. Dudding, president of the Woman's Auxiliary to the Indiana State Medical Association, met with the Auxiliary.

SIXTH COUNCILOR DISTRICT

Sixty-eight members and guests attended the annual meeting of the Sixth District Medical Society May 9 in the Public Library at Liberty.

A business meeting at 10:30 a.m. was conducted by Dr. Frank H. Green, Rushville, president.

Officers for the coming year were elected. Dr. H. N. Smith, Brookville, will head the organization in 1957-58; Dr. J. F. Lewis, Liberty, is vice-president; Dr. Kenneth G. Hill, New Castle, secretary-treasurer; and Dr. William R. Tindall, Shelbyville, alternate councilor. The next meeting of the District will be held in Greenfield, May 8, 1958.

Reports were presented to the delegates by Dr. Tindall on the Blue Shield Advisory Board; and by Dr. Harry P. Ross, Richmond, councilor, on activities of the Council.

J. A. Waggener represented ISMA President Elton R. Clarke in extending greetings from the State Association. R. J. Amick, field secretary, also attended.

Luncheon was served at Talbott's Rose Corner in Dunlapsville.

The afternoon scientific session was held in the Library with Dr. Bernard Rosenak, Department of Medicine, Indiana University School of Medicine, speaking on "Medical Aspects of Gastrointestinal Bleeding," and Dr. J. S. Battersby, associate professor of surgery at the Medical Center, discussing "Surgical Aspects of Gastrointestinal Bleeding." A short question and answer period followed, conducted by Dr. Russell H. Malcolm, Richmond.

Mrs. J. E. Dudding, Hope, president of the Woman's Auxiliary to the Indiana State Medical Association, was a guest of the District Auxiliary which met in the home of Mrs. J. F. Lewis.

Carlson School for Cerebral Palsy announces *two* informal sessions for *ambulatory* Cerebral Palsy patients.

1st session: June 15-August 1
2nd session: August 1-September 15

Located on ocean; swimming pool; supervised therapy.

For information write to *Carlson School, Pompano Beach, Florida.*

News from the County Societies

Thirty members of the **Bartholomew-Brown County Medical Society** attended a dinner in Palms Cafe, Columbus, on April 10.

At a business meeting a general discussion was held concerning mutual problems of the medical profession and the township trustees. A committee was appointed to work out a program more acceptable to both groups than the present arrangement.

A report of legislative action and the Medicare program was given by the ISMA field secretary.

The Salk vaccine program and a proposed mental health clinic for the community were also discussed.

"Proctoscopic and Anoscopic Examinations" was the title of a film shown to members of the **Boone County Medical Society** at their meeting May 7 in Witham Memorial Hospital, Lebanon. Thirteen members were present. The next meeting of the society will be held on September 3.

Twenty members of **Cass County Medical Society** held a dinner meeting May 7 in the Ben-Hur Dining Room, Logansport.

Dr. James M. McFadden, Lafayette, was the guest speaker. He presented a paper on "Protein-Bound Iodine."

A routine business meeting was held.

A business meeting of the **Delaware-Blackford County Medical Society** was held following dinner April 16 in the Delaware Hotel, Muncie. Routine affairs of the society and plans for future meetings were discussed by the 32 members present.

The **Dubois County Medical Society** held its bi-monthly meeting April 11 in the Mullis Tourist Home at Ferdinand with 24 doctors and members of the Auxiliary present. Following dinner they viewed the film "Danger at the Source." Separate meetings of the Society and Auxiliary were then held. General discussion of several current programs was followed by a short report on legislation and the Medicare program presented by R. J. Amick, field secretary.

Dr. Max Sadove of the University of Illinois Medical School presented a paper on "Recent Changes in Pre- and Postoperative Care" before approximately 60 members of the **Elkhart County Medical Society** on April 4.

The meeting was held in the Elkhart Hotel. A short business session followed the scientific program. Kenneth W. Bush, ISMA field secretary, spoke briefly at this time.

A social meeting of the **Fountain-Warren County Medical Society** was held April 4 in the country home of Dr. and Mrs. James W. Crain near Williamsport. Dr. and Mrs. Crain were hosts to eight members and their wives at dinner.

On May 2, six members of the society were entertained at dinner in the Olin Film Division of Olin-Mathieson Chemical Corporation at Covington. Arrangements for the meeting were made by Dr. Edward Humphrey, medical director at the plant. After dinner the society held a business meeting and members enjoyed a tour of the plant where cellophane is manufactured.

Fulton County Medical Society members met April 5 at noon in Woodlawn Hospital, Rochester, with 20 physicians present.

The meeting, a combined medical society and hospital staff session, was devoted to routine business matters, including discussion of the need for a pathologist in the area.

K. W. Bush, field secretary, gave a report of many ISMA headquarters activities, the Indiana General Assembly action, the Medicare program, and stressed the need to get resolutions and reports to be presented at the ISMA annual convention into headquarters office early.

Twelve members of the **Hendricks County Medical Society** held a luncheon meeting in the

O.K. Restaurant in Danville on April 9 at which time plans for raising funds for a county hospital were discussed and a report heard from Robert J. Amick, ISMA field secretary, on the action of the Indiana General Assembly as it affected the medical profession.

Henry County Medical Society members held an evening meeting March 21 in the Henry County Hospital, New Castle. Thirteen members viewed a film on "Unconditional Surrender" and conducted a brief business meeting.

Dr. Donald F. Moore, Indianapolis, was the guest speaker at the April 18 meeting of the society in the Henry County Hospital. He presented a paper on "Changing Concepts of Psychiatry."

Twelve members were present for the meeting.

Jefferson-Switzerland County Medical Society members met in the Elks Club at Madison for dinner April 1 with 21 present.

Following dinner there was a round table discussion of hospital charts, birth records, and several routine matters.

R. J. Amick, representing ISMA, reported on recent legislation and outlined briefly state convention plans, pointing out that it was time for the county societies to prepare any resolutions they wish to present to the House of Delegates at French Lick.

Twenty-three members of **Knox County Medical Society** attended a dinner meeting in the Orchard Room of the Grand Hotel, Vincennes, on April 16. The evening was spent in a general discussion of medical public relations.

Dr. C. L. Williams, acting superintendent of the Dr. Norman Beatty Memorial Hospital at Westville, was host to members of the **LaPorte County Medical Society** and their wives at a dinner meeting in the Personnel building on April 18. Forty-two members and guests attended.

Dr. Williams and Dr. Dean Tasher explained various phases of work at the hospital. Dr. Tasher spoke on the handling of patients and program in the maximum security ward, and Dr. Williams told of problems, particularly with senile patients.

The members held a business meeting during which it was decided to change the date of meeting to the third Tuesday in each month.

Dr. Abdol H. Islami, Iranian physician now practicing in the United States in association with Dr. George Pack, New York cancer specialist, was the guest speaker at the May 25 meeting of the **Indianapolis Medical Society** in the Empire Auditorium. He was introduced by Dr. David H. Sluss, Indianapolis, who met Dr. Islami 15 years ago in Teheran. Dr. Sluss was in command of the 30th Station Hospital when the U.S. Army went into Iran. They took over the old Presbyterian Mission Hospital founded in 1890 by Dr. John G. Wishard, uncle of Dr. William N. Wishard, Indianapolis. Dr. Islami was a medical student there. He has been in America since 1950, is professor of experimental surgery at Seton Hall University School of Medicine, and a lecturer for the "Voice of America"

program. Dr. Islami spoke on "Conditions in Iran and the Middle East."

Dr. James M. Leffel, president, received membership applications of six physicians and referred them to the Council. The following members were elected: Drs. Robert L. Irick, George C. Kaiser, Robert W. Palmer, and J. Paskind, transfer from the Chicago Medical Society.

A memorial tribute to Dr. Earl Baily Rinker was read by Dr. John Rigg, who served as chairman of a resolutions committee with Drs. J. O. Ritchey and Cecil L. Rudesill.

A tribute was also read to Dr. Edward A. Brown, Indianapolis physician for many years and father of Dr. David E. Brown. The resolution was drawn by Drs. M. Joseph Barry, chairman, W. D. Gatch and George Bond.

Members were informed that the Society's television program "Ask Your Doctor" which is presented weekly on WISH-TV had won three awards at the annual public relations awards ceremony of the Marion County Health and Welfare Council.

Twenty members of **Montgomery County Medical Society** heard Dr. Warren E. Goggeshell, Indianapolis, speak on "Rheumatic Fever" at an evening meeting in Culver Union Hospital, Crawfordsville, on April 18.

Parke-Vermillion County Medical Society members held a dinner meeting April 17 in the Vermillion County Hospital, Clinton. The evening was spent informally by the 10 members present.

Pulaski County Medical Society met in Miller's Cafe, Winamac, for a dinner meeting April 12 with five members present. A general discussion of the Medicare program, progress on hospital planning, and the polio vaccination program followed the dinner hour.

Dr. Donald M. Schlegel, Indianapolis, presented a paper on "Vascular Emergencies" at a dinner meeting April 12 of the **Putnam County Medical Society** in the DePauw Union Building, Greencastle.

The 16 members attending the meeting heard a progress report on the polio vaccination drive and voted to contribute $20 per member to the Medical Education Fund.

At the May 10 meeting of the society, also held in the DePauw Union Building, nine members heard a wire recording on "Collagen Diseases." The $20 donations of each member were sent to the AMEF. It was announced that approximately 500 residents of the county between the ages of 1 and 40 had been immunized at the free polio clinics.

The next meeting of the society will be held September 13 in the DePauw Union Building, Greencastle.

Dr. Bruce G. Belt, Baltimore, gave a paper on "The Neurogenic Bladder" before members of the **Shelby County Medical Society** in the W. S. Major Hospital, Shelbyville, on April 3. Eighteen members attended the dinner meeting.

During a business session the ISMA field secretary gave a general report on recent developments at the state level.

The local Salk vaccine program was discussed at the April 4 meeting of the **Sullivan County Medical Society** in the Sullivan Hotel. The nine members present also heard a report on legislation and some ISMA headquarters information from Robert J. Amick, field secretary.

"Civil Defense and the Care of Mass Casualties" was the title of a talk given by Dr. Oscar Hampson of Washington University, St. Louis, before the **Wayne-Union County Medical Society** on April 9. About 40 members and guests were present.

A report on state legislation was given by R. J. Amick, ISMA field secretary, who also answered a number of general questions.

A discussion of the Salk vaccine program concluded the meeting.

Vanderburgh County Medical Society members met in the Rose Room of the Hotel McCurdy, Evansville, for dinner April 9.

Dr. Irwin Levy, associate professor of neurology, Washington University, St. Louis, was the guest speaker. He presented a paper on the general topic "Headaches."

A committee was named to draft memorial resolutions on the death of Drs. Dan Tweedall and Keith Meyer. Drs. John Visher, Charles Schneider and James Matthews were selected. A report of the Polio committee was presented by Dr. E. W. Austin.

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